Proposal for a Section 1915(b) Capitated Waiver Program
Waiver Renewal Submittal

September 23, 1999

US DEPARTMENT OF HEALTH AND HUMAN SERVICES
Health Care Financing Administration
Center for Medicaid and State Operations

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PROPOSAL FOR A SECTION 1915(b) CAPITATED WAIVER PROGRAM
Waiver Renewal Submittal

Introduction

The waiver renewal submittal is for a State's use in requesting renewal of an existing Section 1915(b) waiver program involving Managed Care Organizations (MCOs), Health Insuring Organizations (HIOs) or Prepaid Health Plans (PHPs) that provide contracted services to Medicaid enrollees under their care.

The use of this waiver renewal submittal is voluntary. The purpose is to facilitate the waiver renewal process and, thus, minimize unnecessary and cumbersome paperwork requirements. The completion of this request, used in conjunction with State Medicaid Manual instructions at sections 2106-2112, should expedite the State's effort to request the renewal of an existing waiver and HCFA's effort to process the renewal request.

All waiver renewal requests under section 1915(b) of the Social Security Act (the Act) are subject to the requirements that the State document the cost effectiveness of the project, its effect on enrollee access to and quality of services, and its projected impact on the Medicaid program (42 CFR 431.55(b)(2)). This model section 1915(b) waiver renewal submittal will help States provide sufficient documentation in conjunction with a previously completed waiver application submittal for HCFA to be able to determine whether the statutory and regulatory requirements of section 1915(b) of the Act have been satisfied.

Please note the following qualifications: (1) This version of the capitated waiver renewal submittal does not include new requirements proposed for the Medicaid Balanced Budget Act (BBA) regulation for managed care. Once those regulations are promulgated in their final form, waiver renewal requests will need to document compliance with any new requirements the regulations may contain. (2) States must still have MCO contracts and capitation rates prior approved by their HCFA Regional Office.

HCFA staff will be glad to meet with the State, set up a conference call, or assist the State in any way in the completion of the application. States requesting the renewal of a waiver under only Sections 1915(b)(2), 1915(b)(3), or 1915(b)(4), or a combined 1915(b) and 1915(c), waiver should work with their HCFA Regional Office to identify required submission items from this format.

Instructions

This waiver renewal submittal builds upon the new 1999 format for an initial waiver request. It is essentially the same document, with two changes: each section now starts with a request for monitoring results from the previous two-year waiver period, and asks for changes proposed for the next waiver period. In the 1999 initial submittal we asked

for a description of the waiver program. In this document we ask not only for the program description for the next two years, but a description/confirmation of what occurred in the previous two years.

Each section now starts with one or more items under the heading “Previous Waiver Monitoring.” States are asked a couple questions (as appropriate to each Section). First, States are asked to identify any variance between what they said they would do in the last waiver application and what actually happened in the last two years. In a waiver renewal process, HCFA determines whether States adhered to the program descriptions and activities in the previous waiver application. Changes to the waiver program should not be made without obtaining HCFA approval for a modification to the waiver.

In some sections, a second question in “Previous Waiver Monitoring” asks for the results of monitoring various aspects of the waiver program over the previous 2-year waiver period. Please provide a summary of the State’s monitoring results, including any breakdown available by sub-populations (i.e., if you have different or additional monitoring for foster care or SSI children than TANF, please indicate).

Following “Previous Waiver Monitoring” is the subsection called “Upcoming Two Year Period.” Its purpose is to give the State the opportunity to describe the waiver program for the next two years. Within this section States are asked to identify any items which reflect a future change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") the item being changed.

Please fill out this form in its entirety. Since this renewal submittal builds on the new 1999 initial submittal, there is not a one-to-one correspondence between sections in this 1999 and the 1995 format. When filling out the “Previous Waiver Monitoring” part of each section, we have tried to identify corresponding sections of the 1995 format when possible. However, States should provide monitoring results from all relevant sections of their previous waiver.

Waiver Submittal Instructions (See State Medicaid Manual 2106)
Please submit an original and four (4) copies of the waiver request to the appropriate office:

For MCO and PCCM programs:

HCFA, Center for Medicaid and State Operations, FCHPG
Attn: Director, Division of Integrated Health Systems
7500 Security Boulevard
Baltimore, MD 21244
For Prepaid Health Plan programs focusing on Behavioral Health or Elderly and Disabled populations:

HCFA, Center for Medicaid and State Operations, DEHPG
Attn: Director, Division of Integrated Health Systems
7500 Security Boulevard
Baltimore, MD 21244

At the same time, send at least one copy of the waiver request to the appropriate HCFA Regional Office. A waiver request submitted under 1915(b) of the Act must be approved, disapproved, or additional information requested within 90 days of receipt, or else the request is deemed granted. The Secretary approves or denies such requests in writing or informs you in writing with respect to any additional information which is needed in order to make a final determination with respect to the request. When additional information is requested, the waiver request must be approved or disapproved within 90 days of receipt of your complete response to the request for additional information, or the waiver request is granted.

The 90-day time period begins (i.e., day number one) on the day the waiver is received by the addressee (i.e., the Secretary, the HCFA Central Office (CO) or Regional Office (RO) designee) and ends 90 calendar days later by which time HCFA must either approve or disapprove the request.

General instructions
States should check all items which apply, and provide additional information when specified. Leaving an item un-checked signifies it is not in the State's waiver program. Please note the following:

- A number of the items are required by federal statute, regulation, or policy. These required items are identified as such either in the instructions or headings for a section, or on an item by item basis. State must check-off these required items to affirm the State's intent to comply. If a required item is not checked, States should explain why it is not.

- All items are applicable to both MCOs and PHPs unless otherwise noted (i.e. only MCO or PHP is referenced in the item)

- For any of the sections that require explanations, if possible, please insert them into the document itself instead of attaching the explanation as an appendix.

- Because this is for a renewal of an existing waiver, HCFA is requesting data or summary results from efforts the State has made during the previous waiver period to ensure compliance, quality of services, enrollee protections, etc. In an effort to ensure a complete submission package and to minimize the amount of additional information requested by HCFA, please be sure to respond to these items as fully as possible so that additional information requests are not necessary.

- If a State modifies the wording of the waiver renewal submittal, please italicize and/or strikeout the modification. States may use italics, underlines, and strikeouts for any State-added information or modification to the standard waiver renewal submittal.

- Please update the table of contents prior to submitting the waiver to HCFA to reflect the current page numbers and appendices.

- Please enclose any attachment directly following the section referenced and number the attachments with the section and question number, (e.g., Attachment C.I.a is the attachment for question a. under point I. Elements of State Quality Strategies in Section C.)

Amendments or modifications during the renewal period

During the renewal period, a State may wish to modify their Section 1915(b) waiver program if an aspect of the program changes. Four (4) copies of the modification request must be submitted to the appropriate CO address listed above. A copy should also be sent to the RO at the same time.

HCFA considers only waiver requests submitted by or through the Governor, State cabinet members responsible for State Medicaid Agency activities, the Director of the State Medicaid Agency, or someone with the authority to submit waiver requests on behalf of the Director.

HCFA reviews the request and makes its recommendation to approve or disapprove the request based on the validity of the request and the documentation that is submitted to support the modification. Approval of modification requests are effective from the date of approval through the end of the renewal period.

HCFA receives a variety of waiver modification requests, which range from being minor in nature to extensive. Regardless of the extent of the needed modification, a State must submit an official request for modification to HCFA as soon as it is aware of the need for a change in its program. The request must be submitted and approved prior to implementation of a change in the waiver program.

Section A. General Impact

I. Background

[Required] Please provide a brief executive summary of the State's 1915(b) waiver program's activities since implementation, including experiences during the previous waiver period(s) and a summary of any program changes either planned or anticipated during the requested renewal period. Please specify the types of stakeholders or other advisory committee meetings that have occurred in the previous waiver period or are expected to occur under the future waiver period. Please include descriptions of any advisory boards that have consumer representation. In addition, please describe any program changes and/or improvements that have occurred as a result of stakeholder involvement during the previous waiver period(s). Please describe any stakeholder involvement in monitoring of the previous waiver period. Finally, to the extent the State enrolls persons with special health care needs, please describe how the various stakeholders have been involved in the development, implementation, and ongoing operation of the program.

Medallion II, a mandatory Managed Care Organization (MCO) program, was built on earlier Department of Medical Assistance Services (DMAS) initiatives to expand the use of managed care organizations for the delivery of health care to Medicaid recipients. Medallion II was created for the purposes of improving access to care, promoting disease prevention, ensuring quality care, and reducing Medicaid expenditures. The program requires mandatory enrollment into a contracted MCO for certain groups of Medicaid recipients. Medallion II has provided the Commonwealth with the most value per taxpayer dollar for the provision of high quality health care and provides an integrated, comprehensive delivery system to qualified recipients.

Medallion II began January 1, 1996 and covered managed care recipients in seven Tidewater localities. The program expanded in November of 1997 to an additional six cities and counties adjacent to Tidewater. At that time, Medallion II MCOs administered Medicaid services to approximately 80,000 Medicaid recipients.

As a result of the success of Medallion II in the Tidewater area, DMAS further expanded Medallion II to an additional 33 cities and counties in Central Virginia in April 1999. These cities and counties included Richmond, Hopewell, Petersburg and their surrounding counties. Effective October 1, 2000, Medallion II expanded to nine localities including Fredericksburg and Mecklenburg. At that time, the Medallion II MCOs administered Medicaid services to approximately 160,000 Medicaid individuals.

On December 1, 2001, the Department expanded Medallion II into 48 additional localities including the areas of Danville, Roanoke, Charlottesville, and Northern Virginia. To date, the Medallion II program operates in 103 localities and serves approximately 245,000 Medicaid recipients. The Medallion II program was modified for this expansion to allow the MEDALLION and the Medallion II programs to operate concurrently in the same area. This affected 33 areas where both programs are operating concurrently. In order to implement this expansion, the Centers for Medicare and Medicaid Services (CMS) 1915(b) waiver was modified, and the Medallion II regulations were changed to support the initiative. During the upcoming waiver period, additional populations and/or localities may be added to Medallion II. DMAS will seek approval from CMS prior to implementing any changes.

As of December 2001, seven MCO partners serve the Medallion II program. They are: Trigon HealthKeepers Plus by HealthKeepers, Trigon HealthKeepers Plus by Peninsula Health Care, Trigon HealthKeepers Plus by Priority Health Care, Sentara Family Care, Southern Health Care*N*et, UNICARE Health Plan of Virginia, and Virginia Premier. Five of the current MCOs have been accredited by a national accreditation organization. Four have received excellent status from the National Committee for Quality Assurance (NCQA). One MCO, which entered into an agreement with DMAS in December 2001, has been in operation for less than one year and is not yet eligible to apply for NCQA accreditation. The new MCO's procedures for clinical practice guidelines were evaluated as part of their proposal review and found to meet the State's standards. Medallion II has been successful in enhancing access and availability of care by requiring MCOs to maintain an adequate network of physicians, hospitals, ancillary, transportation, and specialty providers. Medallion II promotes preventive care services as well as the continuity and appropriateness of care. The MCOs provide extensive member services, including 24-hour nurse advice lines, as well as offering enhanced services such as adult dental and vision services, enhanced pre-natal programs, case management services, and group and individualized health education. See Attachment A.I. for a copy of the current Medallion II Managed Care contract.

In response to questions regarding stakeholder issues and involvement in the DMAS's planning and operations, following are some of DMAS's advisory committees: State Board of Medical Assistance Services, DMAS Managed Care Advisory Committee (MAC), the Pre-Natal, Infant, Children, and Special Needs Group (PIC), the Pharmacy Liaison Committee, and the DMAS Dental Advisory Committee. Members of these committees include: providers from numerous arenas, representatives from various state

agencies that play a role in serving Medicaid recipients such as the Virginia Department of Health (re: Title V), the Virginia Department of Social Services (re: enrollment and eligibility issues), the Virginia Department of Education (re: school-based services), and the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services (re: Part C), and advocates representing a broad range of interests, particularly special needs populations. DMAS committees meet regularly, and members are encouraged to provide input on current and proposed programs.

DMAS holds periodic Managed Care Advisory Committee (MAC) meetings which include both consumer and agency representation. This year, regional MAC meetings were added. The MAC provides a forum for discussion of special needs issues. The Committee was established to improve communications with providers, recipients, partner agencies, and other interested parties in the healthcare arena. MAC members also receive and review Quality Improvement (QI) strategy. The committee consists of representatives from the Virginia Pharmacists Association, Virginia Primary Care Associates, MCV Hospitals, Medical Society of Virginia, Virginia Association of Health Plans, Virginia Department of Health, Community Care Network of Virginia (representing rural health), Virginia Institute for Developmental Disabilities, UVA Health Services Foundation, UVA Medical Center, Virginia Poverty Law Center, Community Health Associates Physician Organization (local physician organization), Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services, Virginia Department of Social Services, Center for Pediatric Research of Eastern Virginia Medical School as well as the MCOs participating in Medallion II. See Attachment A.I. for a sample list of attendees at a MAC meeting held in Richmond.

DMAS and the Virginia Department of Health (VDH) co-chair the Prenatal, Infant, Children, and Special Needs Committee (PIC) which is composed of representatives from the VDH, DMAS, the Department of Social Services, the Department of Mental Health, Mental Retardation, and Substance Abuse, and the MCOs participating in Medallion II. The goal of the committee is to improve access to pre-natal care, address issues of children with special needs, and provide a forum for special needs populations. Title V staff also review the MCO contracts and the waiver.

DMAS also works closely with the Virginia Interagency Councils and the State's Title V staff to ensure that information is disseminated in their organizations. Through this process, families are made aware of their health care choices, the enrollment mechanisms, and resources available. DMAS also works closely with Part C representatives at the Department of

Mental Health, Mental Retardation and Substance Abuse Services and the State's Title V representatives from the Virginia Department of Health to ensure that information regarding managed care issues (such as pre-assignment, enrollment, good cause exemption criteria, covered services, etc.) is disseminated throughout their organizations and to the families they serve. Through this process, families are made aware of their health care choices and other resources which may be available for children with special health care needs.

Following is a list of program changes and/or improvements that have occurred or will occur as a result of stakeholder involvement:

- **Reduced the pre-assignment period.**
- **Increased communications in Spanish.**
- **Maternity letters to individuals who enroll in Medicaid because of pregnancy.**
- **Developed and applied for a dental grant to increase access to dental providers.**
- **DMAS staff involvement in early intervention meetings held by the Virginia Department of Mental Health, Mental Retardation and Substance Abuse.**
- **DMAS participation in a grant recently approved with the Virginia Department of Health on children with special health care needs.**
- **Increased regional meetings: MAC, case managers, Department of Social Services training sessions, and member training sessions.**
- **In response to MAC, DMAS has developed a quick monitoring/ activity report on managed care which is distributed to upper management.**
- **Prenatal, Infant, Children, and Special Needs Group (PIC) – See Attachment A.I. for sample minutes of PIC, Case Managers' group, and MAC meetings.**
- **Conducted a survey of MAC in June 2002 on how we can improve managed care. Members want information electronically, so we are developing a distribution list to update members on issues on an ongoing basis.**

II. General Description of the Waiver Program

Previous Waiver Period

a.____ During the last waiver period, the program operated differently than described in the waiver governing that period. The differences were:

Upcoming Waiver Period -- For items a. through m. of this section, please

identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response.

a. **The Commonwealth of Virginia** requests a waiver under the authority of section 1915(b)(1) of the Act. The waiver program will be operated directly by the Medicaid agency.

b. **Effective Dates:** This waiver renewal is requested for a period of 2 years; effective **December 26, 2002** and ending **December 25, 2004**.

c. **The waiver program is called Medallion II** .

d. **State Contact:** The State contact person for this waiver is **Cindy Bowers** and can be reached by telephone at **(804)371-7568** , or fax at **(804)786-1680** , or e-mail at **cbowers@dmas.state.va.us**, or **Mary Mitchell** by telephone at **(804)786-3594)** or e-mail at **mmitchell @dmas. state.va.us**.

e. **Type of Delivery Systems:** The State will be entering into the following types of contracts with the MCO or PHP. The definitions below are taken from federal statute. However, many "other risk" or "non-risk" programs will not fit neatly into these categories (e.g. a PHP program for mental health carve out is "other risk," but just checking the relevant items under "2" will not convey that information fully). Please note this answer should be consistent with your response in Section A.II.d.1 and Section D.I.

1. √ **Risk-Comprehensive (fully-capitated--MCOs, HIOs, or certain PHPs):** Risk-comprehensive contracts are generally referred to as fully-capitated and require that the contractor be an MCO or HIO. Comprehensive means that the contractor is at risk for inpatient hospital services and any other mandatory State plan service in section 1905(a), or any three or more mandatory services in that section. References in this preprint to MCOs generally apply to these risk-comprehensive entities. Check either (a) or (b), and within each the items that apply:

   (a) √ The contractor is at-risk for inpatient hospital services and any one of the following services:

   i. √ Outpatient hospital services,
   ii. √ Rural health clinic (RHC) services,
   iii. √ Federally qualified health clinic (FQHC) services,
   iv. √ Other laboratory and X-ray services,
   v. ___ Skilled nursing facility (NF) services,

vi.√__ Early periodic screening, diagnosis and treatment (EPSDT) services,
vii.√__ Family planning services,
viii.√__Physician services, and
ix.__√__ Home Health services.

(b)__ The contractor is at-risk for three or more of the above services ((i) through (ix)). Please mark the services in (a) and list the services in Section A.II.d.1.

2.___ **Other Risk (partially-capitated or PHP):** Other risk contracts having a scope of risk that is less than comprehensive are referred to as partially-capitated. PHPs are the contractors in these programs (e.g., a PHP for mental health/substance abuse). References in this preprint to PHPs generally apply to these other risk entities. Please check either (a) or (b); if (b) is chosen, please check the services which apply. In addition to checking the appropriate item, please provide a brief narrative of the other risk (PHP) model, which will be implemented by the State:

(a)__ The contractor is at-risk for inpatient hospital services,
OR

(b)__ The contractor is at-risk for two or fewer of the below services ((i) through (ix)).

i.___ Outpatient hospital services,
ii.___ Rural health clinic (RHC) services,
iii.___ Federally qualified health clinic (FQHC) services,
iv.___ Other laboratory and X-ray services,
v.___ Skilled nursing facility (NF) services,
vi.___ Early periodic screening, diagnosis and treatment (EPSDT) services,
vii.__ Family planning services,
viii.__ Physician services, and
ix.___ Home Health services.

3.___ **Non-risk:** Non-risk contracts involve settlements based on fee-for-service (FFS) costs (e.g., an MCO contract where the State performs a cost-settlement process at the end of the year). If this block is checked, replace Section D (Cost Effectiveness) of this waiver preprint with the cost-effectiveness section of the waiver preprint application for a FFS primary care case management (PCCM) program. In addition to checking the appropriate items, please provide a brief narrative description of non-risk model, which will be implemented by the State.

4.___ Other (Please provide a brief narrative description of the model. If the model is an HIO, please modify the entire preprint accordingly):

f. **Statutory Authority:** The State's waiver program is authorized under **Section 1915(b)(1) of the Act**, which provides for a capitated managed care program under which the State restricts the entity from or through which a enrollee can obtain medical care.

g. **Other Statutory Authority.** The State is also relying upon authority provided in the following section(s) of the Act:

1._√_ **1915(b)(2)** - A locality will act as a central broker (agent, facilitator, negotiator) in assisting eligible individuals in choosing among competing health plans in order to provide enrollees with more information about the range of health care options open to them. See Waiver Preprint Section A.III.B Enrollment/Disenrollment and Section 2105 of the State Medicaid Manual. This section must be checked if the State has an independent enrollment broker.

2._**__ **1915(b)(3)** - The State will share cost savings resulting from the use of more cost effective medical care with enrollees by providing them with additional services. Please refer to Section 2105 of the State Medicaid Manual. The savings must be expended for the benefit of the enrolled Medicaid beneficiary.

Please list additional services to be provided under the waiver which are not covered under the State plan in Section A.III.d.1 and Appendix D.III. The services must be for medical or health-related care, or other services as described in 42 CFR Part 440, and are subject to HCFA approval.

**** This item was marked in the previous waiver; however, according to a discussion held with our CMS representative, it was determined that Virginia does not participate in the 1915(b)(3) section of this waiver.**

3._√_ **1915(b)(4)** - The State requires enrollees to obtain services only from specified providers who undertake to provide such services and meet reimbursement, quality, and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services. Please refer to Section 2105 of the State Medicaid Manual.

h. **Sections Waived.** Relying upon the authority of the above Section(s), the

State requests a waiver of the following Sections of 1902 of the Act:

1. _√_ **Section 1902(a)(1)** - Statewideness--This Section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. This waiver program is not available throughout the State.

2. _√_ **Section 1902(a)(10)(B)** - Comparability of Services--This Section of the Act requires all services for categorically needy individuals to be equal in amount, duration, and scope. This waiver program includes additional benefits such as case management and health education that will not be available to other Medicaid enrollees not enrolled in the waiver program.

3. _√_ **Section 1902(a)(23)** - Freedom of Choice--This Section of the Act requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State. Under this program, free choice of providers is restricted. That is, individuals enrolled in this program receive certain services through an MCO or PHP.

4. ___ **Section 1902(a)(30)** - Upper Payment Limits--This Section of the Act require that payments to a contractor may not exceed the cost to the agency of providing those same services on a FFS basis to an actuarially equivalent nonenrolled population. Under this waiver, a contractor may receive a capitation rate and any other applicable payment which may cause total payments to the contractor to exceed the upper payment limits for the capitated services in a given waiver year. The waiver must still be cost-effective for the two-year period. An example of a program with this waiver is a partial capitation program, where the State gives the capitated entity (or entities) a bonus (which in conjunction with the capitation payment exceeds the UPL) for reductions in Medicaid expenditures for high cost areas, but the State demonstrates cost-effectiveness on the basis that total waiver program expenditures are less than total without waiver program expenditures.

5. ___ **Other Statutes Waived** - Please list any additional section(s) of the Act the State requests to waive, including an explanation of the request. As noted above, States requesting a combined 1915(b) and 1915(c) waiver should work with their HCFA Regional Office to identify required submission items from this format.

i. Geographical Areas of the Waiver Program: Please indicate the area of the State where the waiver program will be implemented. (Note: If the State wishes to alter the waiver area at any time during the waiver period, an official waiver modification request must be submitted to HCFA):

1. ** Statewide -- all counties, zip codes, or regions of the State have managed care (Please list in the table below) or

****This was checked in the previous waiver renewal submission with the anticipation of Medallion II going statewide in future expansions. This did not occur during the current waiver period and is not anticipated to occur during the upcoming waiver period.**

2. √** Other (please list in the table below):

A modification of the waiver will be requested from CMS if DMAS decides to expand into areas of the State that are not listed in the following chart during the upcoming waiver period.

Regardless of whether item 1 or 2 is checked above, please list in the chart below the areas (i.e., cities, counties, and/or regions) and the name and type of entity (MCO, PHP, HIO, or other entity) with which the State will contract:

Geographic Areas of the Waiver Program
1 = Trigon HealthKeepers Plus by Priority Health Care,Inc.
2 = Trigon HealthKeepers Plus by Peninsula Health Care, Inc.
3 = Trigon HealthKeepers Plus by HealthKeepers, Inc.
4 = Virginia Premier Health Plans, Inc.
5 = Sentara Family Care
6 = CareNet Southern Health Services, Inc.
7 = UNICARE Health Plan of Va.
8 = MEDALLION PCCM Program, Commonwealth of Virginia, DMAS

City/County/Region	Name of Entity	Type of Entity
Cities:		
Alexandria	7, 8	MCO, PCCM
Arlington	7, 8	MCO, PCCM
Bedford	4, 8	MCO, PCCM
Buena Vista	4, 8	MCO, PCCM
Charlottesville	4, 5, 7	MCO
Chesapeake	1, 4, 5	MCO
Colonial Heights	3, 4, 5, 6	MCO
Danville	5, 8	MCO, PCCM
Emporia	3, 4, 5	MCO
City/County/Region	**Name of Entity**	**Type of Entity**
Fairfax City	7, 8	MCO, PCCM
Falls Church	7, 8	MCO, PCCM

Franklin	1, 4, 5	MCO
Fredericksburg	3, 4, 5, 6	MCO
Hampton	2, 4, 5	MCO
Harrisonburg	4, 5	MCO
Hopewell	3, 4, 5, 6	MCO
Lexington	4, 8	MCO, PCCM
Manassas	7, 8	MCO, PCCM
Manassas Park	7, 8	MCO, PCCM
Martinsville	4, 8	MCO, PCCM
Newport News	2, 4, 5	MCO
Norfolk	1, 4, 5	MCO
Petersburg	3, 4, 5, 6	MCO
Poquoson	2, 5	MCO
Portsmouth	1, 4, 5	MCO
Radford	4, 8	MCO, PCCM
Richmond	3, 4, 5, 6	MCO
Roanoke	4, 8	MCO, PCCM
Salem	4, 8	MCO, PCCM
Staunton	4, 5	MCO
Suffolk	1, 4, 5	MCO
Virginia Beach	1, 4, 5	MCO
Waynesboro	4, 5	MCO
Williamsburg	2, 5	MCO
Counties:		
Accomack	1, 4, 5	MCO
Albemarle	4, 5, 7	MCO
Amelia	3, 4, 5, 6	MCO
Augusta	4, 5	MCO
Bedford	4, 8	MCO, PCCM
Botetourt	4, 8	MCO, PCCM
Brunswick	3, 4, 5	MCO
Buckingham	5, 7	MCO
Caroline	3, 4, 5. 6	MCO
Charles City	3, 4, 5, 6	MCO
Charlotte	5, 8	MCO, PCCM
Chesterfield	3, 4, 5, 6	MCO
Culpeper	4, 8	MCO, PCCM
Cumberland	3, 4, 5, 6	MCO
Dinwiddie	3, 4, 5, 6	MCO
Essex	2, 5, 6	MCO
Fairfax	7, 8	MCO, PCCM
Fauquier	7, 8	MCO, PCCM
Floyd	4, 8	MCO, PCCM

City/County/Region	Name of Entity	Type of Entity
Fluvanna	5, 7	MCO
Franklin	4, 8	MCO, PCCM
Giles	4, 8	MCO, PCCM
Gloucester	2, 5	MCO
Goochland	3, 4, 5, 6	MCO
Greene	4, 5, 7	MCO
Greensville	3, 4, 5	MCO
Halifax	3, 5	MCO
Hanover	3, 4, 5, 6	MCO
Henrico	3, 4, 5, 6	MCO
Henry	4, 8	MCO, PCCM
Isle of Wight	2, 5	MCO
James City County	2, 5	MCO
King and Queen	2, 5, 6	MCO
King George	3, 4, 5, 6	MCO
King William	2, 4, 5, 6	MCO
Lancaster	5, 6	MCO
Loudoun	7, 8	MCO, PCCM
Louisa	4, 5, 7	MCO
Lunenburg	3, 4, 5, 6	MCO
Madison	4, 5, 7	MCO
Mathews	2, 5, 6	MCO
Mecklenburg	3, 4, 5, 6	MCO
Middlesex	2, 5, 6	MCO
Montgomery	4, 8	MCO, PCCM
Nelson	5, 7	MCO
New Kent	3, 4, 5, 6	MCO
Northampton	1, 4, 5	MCO
Northumberland	2, 5, 6	MCO
Nottoway	3, 4, 5, 6	MCO
Orange	4, 5, 7	MCO
Patrick	4, 8	MCO, PCCM
Pittsylvania	5, 8	MCO, PCCM
Powhatan	3, 4, 5, 6	MCO
Prince Edward	3, 4, 5	MCO
Prince George	3, 4, 5, 6	MCO
Prince William	7, 8	MCO, PCCM
Pulaski	4, 8	MCO, PCCM
Richmond	2, 5, 6	MCO
Roanoke	4, 8	MCO, PCCM
Rockbridge	4, 8	MCO, PCCM
Rockingham	4, 5	MCO
Southampton	1, 4, 5	MCO
Spotsylvania	3, 4, 5, 6	MCO
City/County/Region	**Name of Entity**	**Type of Entity**

Stafford	3, 4, 5, 6	MCO
Surry	2, 4, 5, 6	MCO
Sussex	3, 4, 5, 6	MCO
Westmoreland	3, 4, 5, 6	MCO
Wythe	4, 8	MCO, PCCM
York	2, 5	MCO

*The State should list the actual names of the contracting entities. Cost-effectiveness data should be submitted for every city/county/region listed here as described in Section D.

j. MCO Requirement for Choice: Section 1932(a)(3) of the Act requires States to permit individuals to choose from not less than two managed care entities.

1. _√_ This model has a choice of managed care entities.
   (a) _√_ At least one MCO and PCCM

   In 33 areas of the State, there is only one MCO that is willing to participate in the program and is able to meet DMAS' RFP and contract requirements. In such instances, DMAS offers recipients the choice of the existing MEDALLION PCCM program as the alternative managed care entity where necessary.

   (b) __ One PCCM system with a choice of two or more Primary Care Case Managers (please use the PCCM preprint instead of this capitated preprint)
   (c) _√_ Two or more MCOs
   (d) __ At least one PHP and a combination of the above entities

2. ___ This model is an HIO.

3. ___ Other: the State requests a waiver of 1932(a)(3). Please list the reasons for the request (Please note: The exception to choice in rural areas, under Section 1932(a)(3) will not apply until final promulgation of the Balanced Budget Act Medicaid Managed Care regulations):

k. Waiver Population Included: The waiver program includes the following targeted groups of beneficiaries. Check all items that apply:

1. _√_ Section 1931 Children and Related Poverty Level Populations (TANF/AFDC)

2. _√_ Section 1931 Adults and Related Poverty Level Populations,

including pregnant women (TANF/AFDC)

3. _√_ Blind/Disabled Children and Related Populations (SSI)

4. _√_ Blind/Disabled Adults and Related Populations (SSI)

5. _√_ Aged and Related Populations (Please specify: SSI, QMB, Medicare, etc.) **Excludes Medicare recipients.**

6. ___ Foster Care Children

7. ___ Title XXI CHIP - includes an optional group of targeted low income children who are eligible to participate in Medicaid if the State has elected the State Children's Health Insurance Program through Medicaid

8. ___ Other Eligibility Category(ies)/Population(s) Included - If checked, please describe these populations below.

9. _√_ Other Special Needs Populations. Please ensure that any special populations in the waiver outside of the eligibility categories above are listed here (Please explain further in Section F. Special Populations)

Unless institutionalized, the following are included:

i. _**_ Children with special needs due to physical and/ or mental illnesses,
ii. _**_ Older adults,
iii. ___ Foster care children,
iv. _**_ Homeless individuals,
v. _**_ Individuals with serious and persistent mental illness and/or substance abuse,
vi. _**_ Non-elderly adults who are disabled or chronically ill with developmental or physical disability, or
vii. _√**_ Other (please list): **Individuals with special needs due to physical and/or mental illnesses**

I. Excluded Populations: The following enrollees will be excluded from participation in the waiver:

1. _√_ have Medicare coverage, except for purposes of Medicaid-only services;

2. _√*_ have medical insurance other than Medicaid;

3. _√_ are residing in a nursing facility;

4. _√_ are residing in an Intermediate Care Facility for the Mentally

Retarded (ICF/MR);

5.___ are enrolled in another Medicaid managed care program;

6.√** have an eligibility period that is less than 3 months;

7.___ are in a poverty level eligibility category for pregnant women;

8.___ are American Indian or Alaskan Native;

9._√_ participate in a home and community-based waiver;

10. √**receive services through the State's Title XXI CHIP program;

11.√_ have an eligibility period that is only retroactive;

12._√_ are included under the State's definition of Special Needs Populations. Please ensure that any special populations excluded from the waiver in the eligibility categories in I. above are listed here (Please explain further in Section F. Special Populations if necessary);

i.___ Children with special needs due to physical and/ or mental illnesses,
ii.___ Older adults,
iii._√_ Foster care children,
iv.___ Homeless individuals,
v.___ Individuals with serious and persistent mental illness and/or substance abuse,
vi.___ Non-elderly adults who are disabled or chronically ill with developmental or physical disability, or
vii._√_ Other (please list):

a. **Individuals who are institutionalized.**
b. **Individuals who are in a subsidized adoption program.**

13._√ have other qualifications which the State may exclude enrollees from participating under the waiver program. Please explain those reasons below:

a. **Individuals who are placed on spend-down.**
b. **Individuals who enter a Medicaid approved hospice program.**
c. **DMAS reserves the right to exclude from participation in the Medallion II managed care program any recipient who has been consistently non-compliant with the policies, procedures, and philosophies of managed care or is threatening to providers, MCO(s), or DMAS. There must be**

sufficient documentation from various providers, the MCO(s), and DMAS of these non-compliance issues and any attempts at resolution. Recipients excluded from the Medallion II program will be converted to the Medicaid fee-for-service network, contingent upon their continued Medicaid eligibility. Recipients excluded from Medallion II through this provision may appeal this decision to DMAS.

d. Individuals, other than students, who permanently live outside their area of residence for greater than 60 consecutive days, except those individuals placed there for medically necessary services funded by the MCO.

m. Automated Data Processing: Federal approval of this waiver request does not obviate the need for the State to comply with the Federal automated data processing systems approval requirements described in 42 CFR Part 433, Subpart C, 45 CFR Part 95, Subpart F, and Part 11 of the State Medicaid Manual.

n. Independent Assessment: The State will arrange for an Independent Assessment of the cost-effectiveness of the waiver and its impact on enrollee access to care of adequate quality. The Independent Assessment is required for at least the first two waiver periods. **This assessment is to be submitted to CMS at least 3 months prior to the end of the waiver period**. [Please refer to SMM 2111 and CMS's "Independent Assessment: Guidance to States" for more information]. Please check one of the following:

1. ** This is the first or second renewal of the waiver. An Independent Assessment has been completed and submitted to HCFA as required.

2. √ Independent Assessments have been completed and submitted for the first two waiver periods. The State is requesting that it not be required to arrange for additional Independent Assessments unless HCFA finds reasons to request additional evaluations as a result of this renewal request. In these instances, HCFA will notify the State that an Independent Assessment is needed in the waiver approval letter.

As part of the 2000 approval, CMS agreed that the Commonwealth does not have to arrange for an Independent Assessment.

III. PROGRAM IMPACT:

In the following informational sections, please complete the required information

to describe your program. The questions should be answered for MCOs and, if applicable, for PHPs.

a. **Marketing** including indirect MCO/PHP marketing (e.g., radio and TV advertising for the MCO/PHP in general) and direct MCO/PHP marketing (e.g., direct mail to Medicaid beneficiaries). For information to enrollees (i.e., member handbooks), see Section H.

Previous Waiver Period

1.___ During the last waiver period, the program marketing policies operated differently than described in the waiver governing that period. The differences were:

2._√_ [Required for all elements checked in the previous waiver submittal] Please describe how often and through what means the State monitored compliance with its marketing requirements [items A.III.a.1-7 of 1999 initial preprint; as applicable in 1995 preprint], as well as results of the monitoring.

DMAS has a dedicated marketing liaison for MCO marketing oversight. MCO contracts require that all marketing materials be submitted for review and approval. MCOs provide quarterly marketing/media updates to DMAS. The marketing liaison reviews, annually or as changes occur, all printed materials, media scripts, television clips, and scale versions of billboards and transit advertising for readability, false or misleading information, and conformance with other contractual requirements. As DMAS is made aware of possible marketing infractions, surveillance is then enforced. We have had no marketing infractions during the past waiver period.

Upcoming Waiver Period Please describe the waiver program for the upcoming two-year period. For items 1. through 7. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response.

1.___ The State does not permit direct or indirect MCO/PHP marketing (go to item “b. Enrollment/Disenrollment”)

2._√_ The State permits indirect MCO/PHP marketing (e.g., radio and TV advertising for the MCO/PHP in general). Please list types of indirect marketing permitted.

a) **Pre-approved informational materials for television, radio, and newspaper dissemination.**
b) **Billboards, point of service displays, and transit cards.**

c) **Marketing at community sites or other approved locations, excluding Department of Social Services eligibility offices and provider offices.**
d) **Hosting or participating in health awareness events, community events, and health fairs pre-approved by DMAS.**
e) **Health screenings offered at community events, health awareness events, and in wellness vans.**

All materials and events are reviewed and approved by DMAS prior to use by the participating MCOs.

3. √ The State permits direct MCO/PHP marketing (e.g., direct mail to Medicaid beneficiaries). Please list types of direct marketing permitted.

DMAS restricts MCO access to potential enrollee data for the purpose of direct marketing. MCOs may develop direct marketing materials, submit them to DMAS for approval, and supply the materials to the state's mailing house contractor for distribution. Distribution occurs only after DMAS releases current mailing databases to the mailing house contractor.

The MCOs must distribute marketing materials to the entire Medicaid managed care eligible population on a city or county-wide basis.

The MCOs must provide to those interested in enrolling adequate, written descriptions of the MCO's rules, procedures, benefits, fees, and other charges, services, and other information necessary for enrollees to make an informed decision about enrollment. Direct marketing can only be done to potential enrollees during open enrollment or expansion periods.

Please describe the State's procedures regarding direct and indirect marketing by answering the following questions and/or referencing contract provisions or Requests for Proposals, if applicable.

4. √ The State prohibits or limits MCOs/PHPs from offering gifts or other incentives to potential enrollees. Please explain any limitation/prohibition and how the State monitors this:

MCOs are permitted to offer free, non-cash promotional items and "give-aways" that do not exceed a combined value of $10 to any individual or family for marketing purposes. Such items must be offered to all Medallion II eligibles for marketing

purposes whether or not the enrollee chooses to enroll in the MCO's plan. MCOs are encouraged to use items that promote good health behavior, i.e., toothbrushes or immunization schedules. The MCOs provide samples of promotional items to DMAS which conducts periodic monitoring at outreach and marketing events.

MCOs are also allowed to offer incentives to their enrolled members for the purposes of retaining membership and/or rewarding for compliance with immunizations, prenatal visits, etc. The incentives are not limited in amount. The MCO must submit all incentive award packages to DMAS for approval prior to implementation.

5.___ The State permits MCO/PHPs to pay their marketing representatives based on the number of new Medicaid enrollees he/she recruited into the plan. Please explain how the State monitors marketing to ensure it is not coercive or fraudulent:

6._√_ The State requires MCO/PHP marketing materials to be translated into the languages listed below (If the State does not translate enrollee materials, please explain):

MCOs must make available documents in languages other than English when five percent (5%) of the MCO's Medicaid eligible population is non-English speaking and speaks a common language. The population will be assessed by Medallion II regions and will only affect documents distributed in the affected regions. Based on census data, Spanish is the only language that is close to, but does not meet, the threshold requirement.

Prior to the expansion into the Northern Virginia area on December 1, 2001, the need for translated documents (other than the pre-assignment and recipients' rights letters) had not been identified. The Northern Virginia area hosts a diverse population. The one MCO in that region has the capability to translate materials into fourteen different languages. Much of the Health Education materials, which are more general, are readily available in these languages. In order to best meet the needs of the diverse Northern Virginia populations, the top 5 language requests for this area have been identified. Available for immediate mailing are enrollment packets and Explanation of Coverage materials in Korean, Vietnamese, Farsi, Spanish, and Urdo.

The State has chosen these languages because (check any that apply):

i.__ The languages comprise all prevalent languages in the MCO/PHP service area.

ii._√_ The languages comprise all languages in the MCO/PHP service area spoken by approximately **_5_** percent or more of the population.

iii.__ Other (please explain):

7.√** The State requires MCO/PHP marketing materials to be translated into alternative formats for those with visual impairments.

8. **MCO Required Marketing Elements**: Listed below is a description of requirements which the State must meet under the waiver program (items 1.a through 1.g). These items are optional PHP marketing elements. If an item is not checked, please explain why. The State:

(a)_√_ Ensures that all marketing materials are prior approved by the State

(b)_√_ Ensures that MCO marketing materials do not contain false or misleading information

(c)_√_ Consults with the Medical Care Advisory Committee (or subcommittee) in the review of MCO marketing materials

Some members of the Board of Medical Assistance Services (BMAS), the entity which acts as the Medical Care Advisory Committee, are also members of the Managed Care Advisory Committee (MAC). As part of the requirements of the MAC, each year members review some, but not all, of the Medallion II marketing materials.

(d)_√_ Ensures that the MCO distributes marketing materials to its entire service area

(e)_√_ Ensures that the MCO does not offer the sale of any other type of insurance product as an enticement to enrollment.

(f)_√_ Ensures that the MCO does not conduct directly or indirectly, door-to-door, telephonic, or other forms of “cold-call” marketing.

(g)_√_ Ensures that MCO does not discriminate against individuals

eligible to be covered under the contract on the basis of health status or need of health services.

b. Enrollment/Disenrollment:

Previous Waiver Period

1.___ During the last waiver period, the enrollment and disenrollment operated differently than described in the waiver governing that period. The differences were:

2. [Required for all elements checked in the previous waiver submittal] Please provide a description of how often and through what means the State has monitored compliance with Enrollment/Disenrollment requirements (items A.III.b of the 1999 initial preprint; items A.8, 9, 17(g-j), 20, and 22 of 1995 preprint). Please include the results from those monitoring efforts for the previous waiver period.

Enrollment reports for all health plan changes and reasons for those changes were provided monthly to DMAS by the enrollment broker. These reports were given to participating MCOs who used the reports for quality improvement and to track member migration. The EQRO also received this information for its annual report. DMAS tracked over 40 reason codes for the movement of recipients from one plan to another.

The state monitored enrollment/disenrollment by reviewing weekly and monthly reports from the enrollment broker that tracked enrollment, disenrollment, plan changes, and complaints. Daily complaints were also received from the DMAS Helpline, internal staff, and managed care division staff. The state conducted on-site monitoring of calls handled through the enrollment broker call center and reviewed all requests for exemptions and plan changes after lock-in occurred.

See Attachment A.III.b.2. for a sample weekly/monthly enrollment, disenrollment, and plan changes report, and see Attachment B.I.b.10 for the Managed Care Complaints Reports for 2001 and 2002.

Upcoming Waiver Period - Please describe the State's enrollment process for MCOs/PHPs by checking the applicable items below. For items 1. through 6. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response.

1. √ **Outreach:** The State conducts outreach to inform potential enrollees, providers, and other interested parties of the managed care program (e.g., media campaigns, subcontracting with community-based organizations or out stationed eligibility workers). Please describe the outreach process, and specify any special efforts made to reach and provide information to special populations included in the waiver program:

DMAS utilizes a multi-faceted approach for outreach to enrollees, providers, and other interested parties consisting of enrollee correspondence, face-to-face client information, and an aggressive campaign for educating individuals who directly serve the Medicaid population.

Each enrollee receives initial and follow-up mailings related to pre-assignment, health plan selection, enrollment process, open enrollment, and covered benefits.

Enrollees also contact the toll-free Managed Care Helpline for individual assistance. The enrollment broker and representatives from the MCOs are routinely dispatched to community health fairs to provide managed care education and information.

Enrollees are sent correspondence in the form of a letter advising them of the impending change in their health care coverage and that more information will be forthcoming. The next correspondence they receive is related to the pre-assignment process, the enrollment process, open enrollment, covered benefits, and comparisons of the available health plans and additional benefits offered by each plan. During the December 2001 expansion, DMAS offered numerous recipient meetings to facilitate their understanding of the Medallion II program and the enrollment process. These meetings were held in each of the expansion regions and were held at varying times to allow for maximum participation. The initial two meetings held in Northern Virginia yielded an average participation of over 100 recipients.

DMAS has offered individual outreach to Medicaid providers through personal visits from three managed care analysts. These analysts maintain a comprehensive understanding of all DMAS managed care programs and are able to provide technical assistance and increase a provider's understanding

on many levels. In addition, information is disseminated to major associates and providers through the regional Managed Care Advisory Committee (MAC) meetings.

DMAS has held quarterly Case Managers' Meetings throughout the various regions of the state. These meetings target participation by case managers, hospital discharge planners, personnel from the Department of Social Services, and other interested parties. A representative from each health plan in that region also attends these meetings. These meetings provide additional opportunities for collaboration and discussion of special needs issues among professionals who provide case management services to MCO enrollees with special needs. Previous quarterly meetings have focused on topics such as high risk prenatal services, services for children with special healthcare needs, transition of medical care for recipients from MEDALLION to Medallion II, the MCO referral and prior authorization process, HIV/AIDs, homeless individuals, individuals with disabilities, EPSDT, and the Part C process and exclusion.

****DMAS plans to continue offering these case managers meetings; however, prior meetings were held quarterly in one location. As a result of the large geographical area covered by the last expansion, a positive acceptance and increase in attendance at the case manager meetings, and DMAS' goal to assist case managers in all areas of their Medicaid health care concerns, DMAS now conducts meetings regionally throughout the Medallion II areas. Therefore, this necessitates a change in the scheduling of these meetings to a frequency of two to three times per year. The frequency of these meetings will decrease, but the changes in location and accessibility are anticipated to increase participation.**

DMAS also makes available to any requesting local Department of Social Services office individual training sessions with employees to help them understand Medallion II, the pre-assignment and enrollment process, and contact information at both the DMAS and health plan levels for those who need immediate responses and/or help. Thirteen training sessions have been held in the past eight months.

DMAS also has a web site (www.dmas.state.va.us) available to enrollees, providers, and the public that gives information on: overview of managed care, covered services, the enrollment

process, information regarding the Helpline, quality assessment studies, customer satisfaction surveys, and educational materials including MCO comparison charts, preassignment letters, health care rights, etc.

DMAS provides extensive training opportunities to providers and community-based organizations that directly serve the Medallion II population. During each training session, the enrollment process is reviewed as well as information provided to assist providers in assisting patients in making informed consumer choices. Examples of these trainings include:

- **Provider Meetings**
- **Managed Care Advisory Committee meetings**
- **Dental Advisory Committee meetings**
- **Pharmacy Liaison Committee meetings**
- **Local and Regional Department of Social Services Training Meetings**
- **Case Managers' Meetings**
- **School-Based Health**
- **Prenatal and Infant Services Program Meetings**
- **State sponsored Information and Referral Centers**
- **Recipient Meetings**
- **Early Intervention Meetings**

In an attempt to provide the best information, training, and outreach regarding the Medallion II program to the above listed groups or members, DMAS has established or strengthened its partnerships with other state agencies including:

- **Department of Social Services (responsible for determining financial eligibility and on-going eligibility determination)**
- **Department of Health (which includes Title V, Children with Special Health Care Needs, Dental Partnership Issues, Health Departments/Health Clinics, Vaccines for Children, etc.)**
- **Department of Education (School-Based Services)**
- **Department of Mental Health, Mental Retardation and Substance Abuse Services (Early Intervention Services)**

2. _√_ **Administration of Enrollment Process**:

(a)__ State staff conduct the enrollment process.

(b)_√_ The State contracts with an independent contractor(s) (i.e., enrollment broker) to conduct the enrollment process and related activities. The State must request a waiver of 1915(b)(2) in Section A.II.g.1. (Refer to Section 2105 of the State Medicaid Manual)

i. Broker name: **The current enrollment broker is Affiliated Computer Services (ACS), formerly Concera Corporation (which was formerly Benova). An RFP has been issued for this contract and will be awarded in September. The contract will be effective 1/1/03. The functions of the contractor will remain the same under the new contract.**

ii. Procurement method:
(A). _√_ Competitive
(B). ____ Sole source

iii. Please list the functions that the contractor will perform:

Members/recipients

- **A toll free telephone Helpline to provide Medicaid Managed Care recipients with educational information and enrollment services in order to ensure that they understand their health care choices, benefits and responsibilities.**

- **Information to recipients regarding the circumstances whereby they may be excluded from the mandatory Managed Care programs. Information is also provided to recipients regarding when and how they may elect to switch health plans.**

- **Assistance to recipients on the resolution of non-clinical health related problems and referrals to appropriate resources for the resolution of clinical or billing related issues.**

- **Information on how to access participating health plans' member services or complaint/ grievance departments as well as accessing DMAS' Fair Hearing process.**

- **Appropriate information needed to assist recipients in determining which participating health plan best meets their or their family's needs.**

- **Triaging of recipient telephone calls to participating health plans' member services departments, local DSS agencies, or DMAS' Recipient and Provider Helplines.**

- **Eligibility information to recipients and providers.**

- **Assistance to recipients regarding which of the participating health plans a PCP is a member.**

- **Written material via U.S. Mail to callers requesting additional information.**

- **Information about EPSDT services, how to access, scheduling, and related resources.**

- **A specialized mechanism that allows recipients newly enrolled with Medicaid to select a health plan before being placed in pre-assignment. This mechanism eliminates the need for recipients to make a second call once they are moved into pre-assignment.**

- **Translation services via telephone for recipients requiring information in a language other than English.**

- **TDD services for the hearing impaired.**

- **Information to recipients regarding non-covered and carved-out services.**

<u>Interested Parties</u>

- **Information to providers, advocates, and other stakeholders regarding the Managed Care enrollment process.**

- **Consistent, unbiased working relationships with all participating health plans and affiliated agencies in order to foster and maintain close working relationships.**

- **Training and support related to Managed Care services.**

System

- **A telephone system that tracks and reports on all incoming and outgoing telephone calls. The system also provides for monitoring by DMAS of all telephone calls with recipients.**

- **A technology system that interfaces with DMAS' MMIS system to complete the enrollment of recipients into the State's Managed Care program.**

- **A proprietary system for tracking and reporting the types of telephone calls, data entry, and mail activities processed by the contractor.**

- **A comprehensive complaint tracking system with reports being furnished to DMAS on a weekly, monthly, and on an as-needed basis.**

- **An online database of participating health plans' PCPs.**

Reports and Materials

- **Ongoing management reports to DMAS that address all the activities captured in the Call Center. These reports include, but are not limited to: complaint tracking and reporting, recipient changes in health plans, information calls, print material inventories, outreach activities, address changes, exemption requests, etc.**

- **Customized address change reports to DMAS in order to facilitate information exchange between DMAS and DSS to ensure that the most up-to-date address information is reaching DSS in a timely fashion.**

- **The development and coordination of printing key educational materials related to the Managed Care program.**

<u>Outreach</u>

- **Monitoring of marketing and outreach activities at community events. The contractor also provides for on-site enrollments at certain selected community events.**

<u>DMAS</u>

- **The processing of requests for exemptions from the Managed Care program and the data input based on DMAS decisions.**

- **Third party liability (TPL) identification as well as providing appropriate information to recipients regarding the coordination of benefits when TPL is present.**

- **Ongoing assistance to DMAS on an as-needed basis with special tasks and projects.**

- **Strict adherence to performance standards related to all facets of the Managed Care Helpline operation.**

- **Provider and recipient information to DMAS, as needed, to resolve complaints and other issues that impact the Managed Care program as the contractor becomes aware through telephone calls or outreach activities.**

<u>MCOs</u>

- **A Health Status Assessment on all MCO enrollments that are processed through the toll-free Managed Care Helpline. These completed Health Status Assessments are forwarded to the participating MCO that the member has selected.**

<u>Enrollment Broker Staff</u>

- **Ongoing training to the enrollment staff in order to keep them updated on all changes**

related to the Medicaid Managed Care programs.

- **Ongoing monitoring for quality assurance purposes of all Call Center staff responsible for addressing recipient inquiries and questions via the Managed Care Helpline.**

- **Required participation of enrollment broker management staff at certain DMAS meetings.**

(c)__ State allows MCOs/PHPs to enroll beneficiaries. Please describe the process and the State's monitoring.

3. **Enrollment Requirement:** Enrollment in the program is:

(a)_√_ Mandatory for populations in Section A.II.I

(b)__ Voluntary -- See Cost-effectiveness Section D introduction for instructions on inclusion of costs and enrollment numbers (please describe populations for whom it will be voluntary):

(c)___ Other (please describe):

4. **Enrollment:**

(a)_√_ The State will make counseling regarding their MCO/PHP choices prior to the selection of their plan available to potential enrollees. Please describe location and accessibility of sites for face-to-face meetings and availability of telephone access to enrollment selection counseling staff, the counseling process, and information provided to potential enrollees.

Newly eligible recipients to the Managed Care Program are mailed informational materials regarding plan choices, plan benefits, services offered by the participating plans, service areas, program highlights, enrollment instructions, toll-free telephone numbers for additional information on enrollment, specialty services, educational materials, and translation services well in advance of decision making deadlines. Prior to the choice deadline, recipients have access to toll-free assistance from trained choice counselors.

Telephone counseling begins with the verification of the

caller to insure recipient confidentiality. Counselors discuss with the caller their particular need(s) as related to their health care situation. This encompasses a wide range of services related to decision making, resource identification, identifying special health care needs, securing referrals and services, and general information and referral.

(b)___Enrollment selection counselors will have information and training to assist special populations and persons with special health care needs in selecting appropriate MCO/PHPs and providers based on their medical needs. Please describe.

The enrollment selection counselors provide information on MCOs that have programs for individuals with special health care needs (e.g., diabetes, asthma, heart disease). The enrollment selection counselors encourage members to talk with their current providers to determine if their providers belong to a participating MCO in order to maintain continuity of care. Additionally, the enrollment selection counselors complete the Health Status Assessments (HSA) on all newly eligible members or members who change health plans when they call the Helpline. Using this information, the MCOs can initiate appropriate care for those with special health care needs. Enrollment selection counselors refer individuals with special health care needs to case managers at the MCOs, as appropriate. This assessment also indicates the language spoken by the member.

The enrollment broker routinely completes the HSAs when individuals call the Helpline or when they take applications at health fairs or community events. However, there are occasions when individuals call the enrollment broker to make an MCO selection and indicate they have not received any of the materials that DMAS sent them. The enrollment broker will send the materials out to them in the form of a "fulfillment packet" which will include an HSA. This is the only time an HSA is mailed. Please see the HSA in Attachment A.III.b.4.b.

The enrollment broker has an outreach staff member

who, along with staff from DMAS, provides presentations to special groups, including staff and recipients at the local departments of health and social services, advocacy groups, and providers.

(c) √ Enrollees will notify the State/enrollment broker of their choice of plan by:

i. ** mail **DMAS does not encourage notification of enrollment from enrollees by mail. If notification is received by mail, DMAS will accept it.**

ii. √ phone

iii. √ in person at **DMAS or Recipient Meetings**

iv. ___ other:

(d) √ [Required for MCOs and PHPs] There will be an open enrollment period during which the plans will accept individuals who are eligible to enroll. Please describe how long the open enrollment period is and how often beneficiaries are offered open enrollment. Please note if the open enrollment period is continuous (i.e., there is no enrollment lock-in period).

There is an annual 60-day open enrollment period. Enrollees receive a letter, comparison chart, and their Annual Notice of Enrollee Rights and Responsibilities. This includes information on how to access services not covered by the MCO. The open enrollment period is not continuous. The State currently has four open enrollment periods by region. Please refer to open enrollment notification documents in Attachment A.III.b.4.d.

(e) √ Newly eligible beneficiaries will receive initial notification of the requirement to enroll into the program. Please describe the initial notification process.

Pre-assignment packets are sent at least 30 days prior to the effective date of enrollment. They include a letter advising potential enrollees of the MCO choices and instructing them to choose an MCO. Enrollees also receive an MCO brochure and comparison chart that contains information on how to access services, as well as some of their responsibilities, the MCOs in their service area, benefits available through the MCOs, etc. Please refer to Attachment A.III.b.4.e. for the pre-assignment packet and MCO brochure. Refer to

Attachment A.III.b.4.d. for the comparison charts.

(f) __**__ Mass enrollments are expected. Please describe the initial enrollment time frames or phase-in requirements:

(g) __√__ If an enrollee does not select a plan within the given time frame, the enrollee will be auto-assigned or default assigned to a plan.

i. Potential enrollees will have __**one (1)**__ /month(s) to choose a plan.

ii. Please describe the auto-assignment process and/or algorithm. What factors are considered? Does the auto-assignment process assign persons with special health care needs to an MCO/PHP that includes their current provider or to an MCO/PHP that is capable of serving their particular needs?

Before being pre-assigned to an MCO, data on newly eligible or re-eligible recipients are screened by edits to determine the most appropriate MCO based on system algorithms. On a regular basis, recipients pass through these edits in the following order:

- **Previous: A recent relationship (up to 12 months) of enrollment with an MCO.**
- **History: A past relationship or family history (up to 18 months) of enrollment with an MCO.**
- **Random: When a pre-assignment cannot be made by "Previous" or "History" criteria, recipients are pre-assigned randomly in approximately equal numbers between the MCOs, by locality.**
- **In areas of the state where there is one MCO and MEDALLION offered, enrollees are automatically pre-assigned to the MCO.**

While in pre-assignment, recipients may receive services from practically any Medicaid enrolled provider with few restrictions. During this period, Medicaid reimburses the provider on a fee-for-service basis.

(h) __√__ The State provides guaranteed eligibility of __**0**__ months for

all managed care enrollees under the State plan. How and at which point(s) in time are potential enrollees notified of this?

The Commonwealth of Virginia does not guarantee a period of eligibility. The exception is infants up to 12 months of age, as federally required.

(i) _√_ The State allows otherwise mandated beneficiaries to request exemption from enrollment in an MCO/PHP. Please describe the circumstances under which an enrollee would be eligible for exemption from enrollment. In addition, please describe the exemption process:

Individuals may request exemption from enrollment in Medallion II under certain circumstances such as:

- **Individuals who are hospitalized at the scheduled time of enrollment or who are scheduled for an inpatient hospital stay or surgery within 30 calendar days of the enrollment effective date.**
- **Newly eligible individuals who are in the third trimester of pregnancy and who request exclusion by the 15th of the month in which their enrollment becomes effective. Exclusion may be granted only if the member's obstetrical provider (physician or hospital) does not participate with any of the state-contracted MCOs. Requests may be made by the enrollee, MCO, or obstetrical provider.**
- **Individuals who have been preassigned to an MCO but have not yet been enrolled, who have been diagnosed with a terminal condition and who have a life expectancy of six months or less, if they request exclusion.**
- **Certain individuals between birth and age three certified by the Department of Mental Health, Mental Retardation, and Substance Abuse Services as eligible for services pursuant to Part C of the Individuals with Disabilities Education Act.**
- **DMAS, at its discretion, will consider on an individual basis an exemption for children with special health care needs when it is found that the exemption is in the best interest of the child. For consideration, the child's services must be adversely compromised and/or affected by remaining in managed care.**

Requests for exemption are reviewed for compliance with established state plan regulations. DMAS reviews and confirms all exemption requests. The process for exemptions of Part C children is outlined in Attachment A.III.b.4.i. To date, DMAS has received no requests for Part C exemptions.

5. **Disenrollment:**

(a) √ The State allows enrollees to disenroll/transfer between MCOs/PHPs. Please explain the procedures for disenrollment/transfer:

Enrollees may request disenrollment/transfer to another plan for cause at any time. The "good cause" process is highlighted in Section III.b.5.d.

Enrollees are allowed 90 days to change MCOs without cause when enrolled in a new MCO. Enrollees are also allowed to change MCOs during open enrollment which occurs at least every twelve months.

During open enrollment, enrollees are notified through a letter and other informational materials from DMAS of the option to disenroll/transfer from one MCO to another. This information is sent 60 days prior to the effective date. The enrollee must call the enrollment broker's toll free Helpline number to request the change.

The MCO contract provides for automatic re-enrollment of a recipient who is disenrolled solely because he or she loses Medicaid eligibility for a period of two months or less. If the temporary loss of Medicaid eligibility has caused the recipient to miss the annual enrollment opportunity, then the recipient is allowed to disenroll without cause. The MCO contract allows a recipient to select another MCO prior to being automatically re-enrolled with the previous MCO.

Enrollees are also allowed to disenroll without cause when the State imposes an intermediate sanction against an MCO for violation of any of the other requirements of sections 1903(m) or 1932 of the Act and any implementing regulations. The State must notify the

affected enrollees of their right to disenroll.

The member or the member's representative must submit an oral or written request for a good cause change to DMAS. Decisions are based on state exemption regulations. Written responses are provided within 15 business days of DMAS' receipt of the request. Enrollees have a right to appeal to DMAS within 30 days of the decision.

MCOs are required to notify enrollees of their right to transfer. Transfers are processed by the enrollment broker.

(b)___The State does not allow enrollees to disenroll from the PHP.

(c)_√_The State monitors and tracks disenrollments and transfers between MCOs/PHPs. Please describe the tracking and analysis:

Disenrollments and transfers are tracked using weekly and monthly reports produced by the enrollment broker and DMAS. These reports provide detailed and summary information on the number of disenrollments, transfers, and the reasons for these actions.

(d)_√_The State has a lock-in period of _**12**_ months (up to 12 months permitted). If so, the following are required:

i._√__ MCO enrollees must be permitted to disenroll without cause within the first 90 days of each enrollment period with each MCO.

ii ___ PHP enrollees must be permitted to disenroll without cause within the first month of each enrollment period with each PHP

ii._√__MCO enrollees must be notified of their ability to disenroll or change MCOs at the end of their enrollment period at least 60 days before the end of that period.

iii._√__MCO and PHP enrollees have the following good cause reasons for disenrollment are allowed during the lock-in period:

Good cause for disenrollment includes the following:

- **A recipient's desire to seek services from a Federally Qualified Health Center (FQHC) which is not under contract with the recipient's current MCO;**

- **The enrollee moves out of the MCO's service area;**
- **The MCO does not, because of moral or religious objections, cover the service the enrollee seeks;**
- **The enrollee needs related services to be performed at the same time; not all related services are available within the network; and the enrollee's primary care provider or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk;**
- **Performance or nonperformance of service to the recipient by an MCO or one or more of its providers which is deemed by DMAS' external quality review organizations to be below the generally accepted community practice of care. This may include poor quality care;**
- **Lack of access to services covered under the contract or lack of access to providers experienced in dealing with the enrollee's health care needs;**
- **A client has a combination of complex medical factors that, in the sole discretion of DMAS, would be better served under another contracted MCO or PCCM program, if applicable, or provider; or**
- **Other reasons as determined by DMAS which will be considered on a case by case basis.**

(e)__ The State does not have a lock-in, and enrollees in MCOs/PHPs are allowed to terminate or change their enrollment without cause at any time. Please describe the effective date of an enrollee disenrollment request.

6. **MCO/PHP Disenrollment of Enrollees**: If the State permits MCOs/PHPs to request disenrollment of enrollees, please check items below which apply:

(a)__ The MCO/PHP can request to disenroll or transfer enrollment of an enrollee to another plan. If so, **it is important that reasons for reassignment are not discriminatory in any way -- including adverse change in an enrollee's health status and non-compliant behavior for individuals with mental health and substance abuse diagnoses -- against the enrollee**. Please describe the reasons for which the MCO/PHP can request reassignment of an enrollee:

(b)_**_The State reviews and approves all MCO/PHP-initiated

requests for enrollee transfers or disenrollments.

This was checked in error in the last waiver. The State does not allow MCOs to request disenrollment of enrollees.

(c)__ If the reassignment is approved, the State notifies the enrollee in a direct and timely manner of the desire of the MCO/PHP to remove the enrollee from its membership.

(d)__ The enrollee remains a member of the MCO/PHP until another MCO/PHP is chosen or assigned.

c. Entity Type or Specific Waiver Requirements

Previous Waiver Period

1.___ During the last waiver period, the program operated differently than described in the waiver governing that period. The differences were:

Upcoming Waiver Period -- Please describe the entity type or specific waiver requirements for the upcoming two-year period. For items 1. through 4. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response.

1._√__ **Required MCO/PHP Elements:** MCOs/PHPs will be required to comply with all applicable federal statutory and regulatory requirements, including those in Section 1903(m) and 1932 of the Act, and 42 CFR 434 et seq.

2. **Required Elements Relating to Waiver under Section 1915(b)(4):** If the State is requesting a waiver under Section 1915(b)(4) of the Social Security Act, please mark the items that the State is in compliance with:

(a)_√__ The State believes that the requirements of section 1915(b)(4) of the Act are met for the following reasons:

i._√__ Although the organization of the service delivery and payment mechanism for that service are different from the current system, the standards for access and quality of services are the same or more rigorous than those in your State's Medicaid State Plan.

ii.___ MCO/PHP must provide or arrange to provide for the

full range of Medicaid services to be provided under the waiver.

iii. √ MCO/PHP must agree to accept as payment the reimbursement rate set by the State as payment in full.

iv. ___ Per 42 CFR 431.55(f)(2)(i), enrollees residing at a long term care facility are not subject to a restriction of freedom of choice based on this waiver authority unless the State arranges for reasonable and adequate enrollee transfer.

v. √ There are no restrictions that discriminate among classes of providers on grounds unrelated to their demonstrated effectiveness and efficiency in providing services.

3. The State has/will select the MCOs/PHPs that will operate under the waiver in the following manner:

(a) ** The State has used/will use a competitive procurement process. Please describe.

An open cooperative procurement process more accurately describes the current process used by the State to select MCOs that operate under the waiver.

(b) √** The State has used/will use an open cooperative procurement process in which any qualifying MCO/PHP may participate that complies with federal procurement requirements and 45 CFR Section 74.

(c) __ The State has not used a competitive or open procurement process. Please explain how the State's selection process is consistent with federal procurement regulations, including 45 CFR Section 74.43 which requires States to conduct all procurement transactions in a manner to provide to the maximum extent practical, open and free competition.

4. √ Per Section 1932(d) of the Act, the State has conflict of interest safeguards with respect to its officers and employees who have responsibilities related to MCO contracts and the default enrollment process now established for MCOs.

d. SERVICES

Previous Waiver Period

1. √ During the last waiver period, the program operated differently than described in the waiver governing that period.

   In the previous waiver, the following services were to be added to the MCO contracts as covered services: substance abuse treatment for pregnant women, day treatment, residential treatment, and partial hospitalization. These services continue to be reimbursed on a fee-for-service basis. If the addition of these services becomes a possibility, DMAS will then conduct a feasibility study and will notify CMS before implementation.

2. √ [Required for all elements checked in the previous waiver submittal] Please provide a description of how often and through what means the State has monitored compliance with service provision requirements. [items A.III.d.2-6 of the 1999 initial preprint; items A.13, 14, 21 of the 1995 preprint]. Please include the results from those monitoring efforts for the previous waiver period.

   The State monitored compliance with service provision requirements through complaint logs which were sent to CMS on a monthly basis. DMAS also monitored compliance through telephone calls received, face-to-face meetings, letters, and regional meetings.

Upcoming Waiver Period -- Please describe the service-related requirements for the upcoming two year period. For items 1. through 7. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response.

1. The Medicaid services MCO/PHPs will be responsible for delivering, prescribing, or referring to are listed in the chart below. The purpose of the chart is to show which of the services in the State's state plan are/are not in the MCO/PHP contract; which non-covered services are impacted by the MCO/PHP (i.e. for calculating cost effectiveness; see Appendix D.III); and which new services are available only through the MCO/PHP under a 1915(b)(3) waiver. When filling out the chart, please do the following:

(Column 1 Explanation) Services: The list of services below is provided as *an example only. States should modify the list to include:*

-- all services available in the State's State Plan, regardless of whether they will be included or excluded under the waiver

-- subset(s) of state plan amendment services which will be carved out, if applicable; for example, list mental health separately if it will be carved out of physician and hospital services
-- services not covered by the state plan (note: only add these to the list if this is a 1915(b)(3) waiver, which uses cost savings to provide additional services)

(Column 2 Explanation) State Plan Approved: Check this column if this is a Medicaid State Plan approved service. This information is needed because only Medicaid State Plan approved services can be included in cost effectiveness. For 1915(b)(3) waivers it will also distinguish existing Medicaid versus new services available under the waiver.

(Column 3 Explanation) 1915(b)(3) waiver services: If a covered service is not a Medicaid State Plan approved service, check this column. Marking this column will distinguish new services available under the waiver versus existing Medicaid service.

(Column 4 Explanation) MCO/PHP Capitated Reimbursement: Check this column if this service will be included in the capitation or other reimbursement to the MCO/PHP. All services checked in this column should be marked in Appendix D.III in the "Capitated Reimbursement" column.

(Column 5 Explanation) Fee-for-Service Reimbursement: Check this column if this service will NOT be the responsibility of the MCO/PHP, i.e. not included in the reimbursement paid to the MCO/PHP. However, do not include services impacted by the MCO/PHP (see column 6).

(Column 6 Explanation) Fee-for-Service Reimbursement impacted by MCO/PHP: Check this column if the service is not the responsibility of the MCO/PHP, but is impacted by it. For example, if the MCO/PHP is responsible for physician services but the State pays for pharmacy on a FFS basis, the MCO/PHP will impact pharmacy use because access to drugs requires a physician prescription. All services checked in this column should appear in Appendix D.III (in "Fee-For-Service Reimbursement" column). Do not include services NOT impacted by the MCO/PHP (see column 5).

Service (1)	State Plan Approved (2)	1915(b)(3) waiver services (3)	MCO/PHP Capitated Reimburse-ment (4)	Fee-for-Service Reimburse-ment (5)	Fee-for-Service Reimbursement impacted by MCO/PHP (6)

Service (1)	State Plan Approved (2)	1915(b)(3) waiver services (3)	MCO/PHP Capitated Reimburse-ment (4)	Fee-for-Service Reimburse-ment (5)	Fee-for-Service Reimbursement impacted by MCO/PHP (6)
Day Treatment Services	**X**			**X****	
Dental **(all enrollees under 21; limited oral surgery like M/care; dentures under EPSDT; orthodontics under 21)**	**X**		**X**		
Detoxification					
Developmental Disabilities Services					
Durable Medical Equipment	**X**		**X**		
Education Agency Services	**X**			**X**	
Emergency Services	**X**		**X**		
EPSDT	**X**		**X**		
Family Planning Services	**X**		**X**		
Federally Qualified Health Center Services	**X**		**X**		
Home Health – (**limited to 32 visits per year)**	**X**		**X**		
Hospice	**X**			**X**	
Inpatient Hospital	**X**			**X**	

Service (1)	State Plan Approved (2)	1915(b)(3) waiver services (3)	MCO/PHP Capitated Reimburse-ment (4)	Fee-for-Service Reimburse-ment (5)	Fee-for-Service Reimbursement impacted by MCO/PHP (6)
– Psych – **State Psychiatric Hosp**					
Inpatient Hospital – Other – **Gen. Med./ Surgical Acute Care/Psych Unit of a General Acute Care Hosp**.	**X**		**X**		
Immunizations	**X**		**X**		
Lab and x-ray	**X**		**X**		
Mental Health Services **(Community Mental Health Rehabilitative Services)**	**X**			**X**	
Nurse midwife	**X**		**X**		
Nurse practitioner	**X**		**X**		
Nursing Facility	**X**			**X**	
Obstetrical services	**X**		**X**		
Occupational therapy – **limited to 24 visits**	**X**		**X**		
Other fee-for-service services					
Other Outpatient Services – **Mental Health – Clinic Services – limit**	**X**		**X**		

Service (1)	State Plan Approved (2)	1915(b)(3) waiver services (3)	MCO/PHP Capitated Reimburse-ment (4)	Fee-for-Service Reimburse-ment (5)	Fee-for-Service Reimbursement impacted by MCO/PHP (6)
of 26 visits per year					
Other Psych Practitioner	**X**		**X**		
Outpatient Hospital - All Other	**X**		**X**		
Outpatient Hospital - Lab & X-ray	**X**		**X**		
Partial Hospitalization	**X**			**X****	
Personal Care					
Pharmacy	**X**		**X**		
Physical Therapy **– limited to 24 visits**	**X**		**X**		
Physician	**X**		**X**		
Private duty nursing					
Prof. & Clinic and other Lab and X-ray	**X**		**X**		
Psychologist	**X**		**X**		
Rehabilitation Treatment Services – **Audiology**	**X**		**X**		

Service (1)	State Plan Approved (2)	1915(b)(3) waiver services (3)	MCO/PHP Capitated Reimburse-ment (4)	Fee-for-Service Reimburse-ment (5)	Fee-for-Service Reimbursement impacted by MCO/PHP (6)
Respiratory care					
Rural Health Clinic	**X**		**X**		
Speech Therapy – **limited to 24 visits**	**X**		**X**		
Substance Abuse Treatment Services **for pregnant women**	**X**			**X**	
Testing for sexually transmitted diseases (STDs)	**X**		**X**		
Transportation – Emergency	**X**		**X**		
Transportation - Non-emergency	**X**		**X**		
Vision Exams and Glasses **for ages under 21**	**X**		**X**		
Other – **Residential Treatment**	**X**			**X****	
Other Pharmacy Services -- Please specify (e.g., Health Drugs)					
Other Mental Health Services- Please Specify					

Service (1)	State Plan Approved (2)	1915(b)(3) waiver services (3)	MCO/PHP Capitated Reimburse-ment (4)	Fee-for-Service Reimburse-ment (5)	Fee-for-Service Reimbursement impacted by MCO/PHP (6)
Other Inpatient Services - Please Specify					

2. **Emergency Services (Required)**. The State must ensure enrollees in MCOs/PHPs have access to emergency services without prior authorization even if the emergency provider does not have a contractual relationship with the entity. For PHPs, "emergency services" means covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish such services, and are needed to evaluate or stabilize an emergency medical condition.
For MCOs, "emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.

(a)__ The State has a more stringent definition of emergency medical condition for MCOs or PHPs than the definition above. Please describe.

The State takes the following required steps to ensure access to emergency services. If an item below is not checked, please explain.

(b)_√_ The State ensures enrollee access to emergency services by requiring the MCO/PHP to provide adequate information to all enrollees regarding emergency service access (see Section H. Enrollee Information and Rights)

(c)_√_ The State ensures enrollee access to emergency services by including in the contract requirements for MCOs/PHPs to cover the following. Please note that this requirement for coverage does not stipulate how, or if, payment will be

made. States may give MCOs/PHPs the flexibility to develop their own payment mechanisms, e.g. separate fee for screen/evaluation and stabilization, bundled payment for both, etc.

i. √ For the screen/evaluation and all medically necessary emergency services when an enrollee is referred by the PCP or other plan representative to the emergency room, regardless of whether the prudent layperson definition was met,

ii. √ The screen/evaluation, when an absence of clinical emergency is determined, but the enrollee's presenting symptoms met the prudent layperson definition,

iii. √ Both the screening/evaluation and stabilization services when a clinical emergency is determine

iv. √ Continued emergency services until the enrollee can be safely discharged or transferred,

v. √ Post-stabilization services which are pre-authorized by the MCO/PHP, or were not pre-authorized, but the MCO/PHP failed to respond to request for pre-authorization within one hour, or could not be contacted (Medicare+Choice guideline). Post-stabilization services remain covered until the MCO/PHP contacts the emergency room and takes responsibility for the enrollee.

3. **Family Planning**: In accordance with 42 CFR 431.51(b), preauthorization by the enrollee's PCP (or other MCO/PHP staff), or requiring the use of participating providers for family planning services is prohibited under the waiver program.

(a) √ Enrollees are informed that family planning services will not be restricted under the waiver.

(b) √ Non-network family planning services are reimbursed in the following manner:

i. √ The MCO/PHP will be required to reimburse non-network family planning services

ii. ___ The MCO/PHP will be required to pay for family planning services from network providers, and the State will pay for family planning services from non-network providers

iii.___The State will pay for all family planning services, whether provided by network or non-network providers

iv.___ The State pays for non-network services and capitated rates were set accordingly.

v.___ Other (please explain):

(c) __ Family planning services are not included under the waiver.

4._√_ **Other Services to Which Enrollee Can Self-Refer**: In addition to emergency care and family planning, the State requires MCOs/PHPs to allow enrollees to self-refer (i.e. access without prior authorization) to the following services (Please note whether self-referral is allowed only to network providers or to non-network providers):

MCOs must permit any female enrollee of age 13 or older direct access to a participating obstetrician-gynecologist for annual examinations and routine health care services without prior authorization from the primary care physician.

5.___ **Monitoring Self-Referral Services**. The State places the following requirements on the MCO/PHP to track, coordinate, and monitor services to which an enrollee can self-refer:

6._√__**Federally Qualified Health Center** (FQHC) Services will be made available to enrollees under the waiver in the following manner (indicate one of the following, and if the State's methodology differs, please explain in detail below):

(a)__ The program is **voluntary**, and the enrollee can disenroll at any time if he or she desires access to FQHC services. No FQHC services will be required to be furnished by the MCO/PHP to the enrollee during the enrollment period.

(b)_√_ The program is **mandatory** and the enrollee is guaranteed a choice of at least one MCO/PHP which has at least one FQHC as a participating provider. If the enrollee elects not to select the MCO/PHP that gives him or her access to FQHC services, no FQHC services will be required to be furnished to the enrollee while the enrollee is enrolled with the MCO/PHP he or she selected. In any event, since reasonable access to FQHC services will be available under

the waiver program, FQHC services outside the program will not be available.

Please explain how the State will guarantee all enrollees will have a choice of at least one MCO/PHP with a participating FQHC:

FQHC contracting is highly encouraged by DMAS. Most FQHCs have contracted with an MCO; however, as part of our good cause and exemption process, an individual may be exempted from participation in an MCO if an FQHC is requested and the MCO is unable to meet this need.

(c)__ The program is **mandatory** and the enrollee has the right to obtain FQHC services **outside** this waiver program through the regular Medicaid Program.

7. **EPSDT Services:** The State has coordinated and monitored EPSDT services under the waiver program as follows:

(a) __ The State requires MCOs/PHPs to report EPSDT screening data, including behavioral health data (e.g., detailed health and development history including physical and mental health assessments). Please describe the type and frequency of data required by the State.

(b)_√_ EPSDT screens are covered under this waiver. Please list the State's EPSDT annual screening rates, including behavioral components, for previous waiver period. (Please note*: HCFA requested that each State obtain a baseline of EPSDT and immunization data in the initial application. That baseline could have been the data reported in the HCFA 416 report or it may be rates/measures more specific to the Medicaid managed care population. Those rates from the previous submission should be compared to the current rates and the reports listed here.) Please describe whether screening rates increased or decreased in the previous waiver period and which activities the State will undertake to improve the percentage of screens administered for enrollees under the waiver.

The annual CMS 416 report submitted in April 2002 indicated incremental improvement over periods previously reported. The report combined both fee-for-service data and our contracted Medicaid MCOs' encounter data. Sustained improvement has been

realized over the last four reporting periods for the overall screening ratio. The FY 97-98 screening ratio was 59%. Subsequent reporting periods have yielded participant ratios of 72%, 75%, and 79% for fiscal years 98-99, 99-00, and 00-01, respectively.

DMAS continues to partner with participating providers, recipients, other social and public health agencies, and the community to promote Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services. Promotion is primarily done in the form of provider training, marketing materials (posters and brochures), and through our collaboration with the Virginia Department of Health, "Bright Futures". Bright Futures is a Health Services and Resources Administration program with a vision, a philosophy, a set of expert guidelines, and a practical developmental approach to providing health supervision for children of all ages, birth through adolescence.

(c) __√__ Immunizations are covered under this waiver. Please list the State's immunization rates for previous waiver period. What activities will the State initiate to improve immunization rates for enrollees under the waiver?

See Attachment A.III.d.7.c. for a study completed by Delmarva Foundation, Inc. on the State's immunization rates.

DMAS is a member of a statewide coalition, Project Immunize, whose goal is to increase immunizations across the life span. The coalition promotes linkages between WIC and immunizations and has developed a program to increase the number of children who receive appropriate vaccinations at birth. Another program, "Immunize Before You Graduate", is aimed at increasing immunizations for adolescents. DMAS is also a participant in the GIPRA Immunization Project and supports the Virginia Department of Health's "Healthy Beginnings".

The MCOs also promote various activities to increase immunization rates: sending out reminder postcards and notices in provider newsletters; provider profiling in order to determine the percentage of eligible children

who have been immunized; health education; and outreach activities where information on immunizations is available to enrollees.

(d)__√__Managed care providers are required to enroll in the Vaccines for Children Program. If not, please explain.

(e)____Mechanisms are in place to coordinate school services with those provided by the MCO/PHP. Please describe and clarify the aspects of school services that are coordinated including IEPS, IFSPs, special education requirements, and school-based or school-linked health centers (e.g., plan requirements for PCP cooperation or involvement in the development of the IEPs).

DMAS conducts annual training sessions with school divisions which include information on Medicaid managed care programs and the need to communicate and cooperate with the Medicaid programs' providers. This same information is also in DMAS' School Health Manual.

(f)__√__ Mechanisms are in place to coordinate other aspects of EPSDT (e.g., dental, mental, Title V, etc) with those provided by the MCO/PHP. Please describe.

DMAS' contract with the MCOs requires provision and/or coordination of services with other programs as necessary. The EPSDT section includes the following requirements:

- **The MCOs will ensure that a participating child is periodically screened and treated in conformity with the periodicity schedule. To comply with this requirement, the MCOs will design and employ policies and methods to ensure that children receive re-screening and treatment when due.**

- **Each MCO will incorporate EPSDT requirements in its quality assurance activities.**

- **When a developmental delay has been identified by the provider, the MCO will ensure that appropriate referrals are made and documented in the patient's medical records.**

Section B. Access and Capacity

A Section 1915(b) waiver program serves to improve an enrollee's access to quality medical services. A waiver must assure that services provided are of adequate amount, are provided within reasonable time frames, and are furnished within a reasonable distance from the residence of the enrollees in the program. Furthermore, the proposed waiver program must not substantially impair access to services and access to emergency and family planning services must not be restricted.

I. Access Standards

Previous Waiver Period

a.___ During the last waiver period, the access standards of the program were operated differently than described in the waiver governing that period. The differences were:

Upcoming Waiver Period -- For items a. through c. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Please describe the State's availability standards for the upcoming waiver period.

a. **Availability Standards**: The State has established maximum distance and/or travel time requirements, given clients normal means of transportation, for MCO/PHP enrollees' access to the following. Check any that apply (1-9). For each item checked, please describe the standard and answer monitoring questions 10, 11 and 12.

1. √ PCPs (please describe your standard):

In urban areas, there must be a choice of at least two PCPs located within a 15 mile radius and no more than 30 minutes travel time from any enrollee unless the MCO has a DMAS-approved alternative time or distance standard. In rural areas, there must be a choice of at least two PCPs located within a 30 mile radius and no more than 60 minutes travel time from any enrollee unless the MCO has a DMAS-approved alternative time or distance standard. Travel time is determined based on driving during normal traffic conditions.

2. √ Specialists (please describe your standard):

Travel distance may not exceed 30 miles in urban areas and may not exceed 60 miles in rural areas unless the enrollee chooses to exceed those distances. Also, obstetrical services must be available within no more than 45 minutes travel time from any pregnant woman in rural areas. An exception to this

standard may be granted when the MCO has established, through utilization data provided to DMAS, that a normal pattern for securing health care services within an area falls beyond the prescribed travel distance, or the MCO and its PCPs are providing a higher skill level or specialty of service that is unavailable within the service area, such as treatment of cancer, burns, or cardiac diseases.

3.___ Ancillary providers (please describe your standard):

This item is not checked since DMAS does not have explicit standards for access to ancillary providers. However, as stated in the MCO contract, MCOs must ensure adequate and accessible access to ancillary providers in the areas of dental, vision, pharmacy, and mental health services.

4.___ Pharmacies (please describe your standard):

This item is not checked since DMAS does not have explicit standards for access to pharmacies. However, as stated in the MCO contract, MCOs must ensure adequate and accessible access to ancillary providers in the areas of dental, vision, pharmacy, and mental health services.

The selection and authorization process of MCOs to deliver Medicaid services ensures that each MCO has a pharmacy network with major chain pharmacies included in the network. In Virginia, the major chain pharmacies are located in every urban and rural community. Virginia Medicaid MCOs collectively include participation from every major chain of pharmacies. Recipients choose their MCO and may consider the pharmacy network in their selection.

5.√** Hospitals (please describe your standard):

MCOs must ensure that an enrollee is not required to travel in excess of 30 miles in an urban area and 60 miles in a rural area to secure initial contact with hospitals, special hospitals, psychiatric hospitals, etc. unless the enrollee so chooses. An exception to this standard may be granted when the MCO has established, through utilization data provided to DMAS, that a normal pattern for securing health care services within an area falls beyond the prescribed travel distance or the MCO and its PCPs are providing a higher skill level or specialty of service that is unavailable within the service area, such as treatment

of cancer, burns, or cardiac diseases.

MCOs must maintain in their networks a sufficient number of acute care hospital facilities to provide inpatient covered Medicaid services to its enrollees. Recipients choose their MCO and may consider the hospital network in their selection. DMAS closely monitors MCO networks with respect to hospital accessibility and places great emphasis on this area both during waiver expansion and in the quarterly network evaluations.

6.___ Mental Health (please describe your standard):

This item is not checked since DMAS does not have explicit standards for access to mental health services. However, as stated in the MCO contract, MCOs must ensure adequate and accessible access to ancillary providers in the areas of dental, vision, pharmacy, and mental health services.

7.___ Substance Abuse Treatment Providers (please describe your standard):

8.__√__ Dental (please describe your standard):

MCOs must ensure that an enrollee is not required to travel in excess of 30 miles in an urban area and 60 miles in a rural area to secure initial contact with dentists, etc. Also, as stated in the MCO contract, MCOs must ensure adequate and accessible access to ancillary providers in the areas of dental, vision, pharmacy, and mental health services.

9.___ Other providers (please describe your standard)

10. Please explain how often and how the State monitors compliance and what incentives/sanctions/enforcement the State makes with each of the standards described above.

Quarterly network analyses are performed by DMAS. In addition, complaint logs from the enrollment broker, MCOs, and DMAS are monitored for any level of enrollee dissatisfaction regarding access to PCPs, specialists, or to any other covered Medicaid services. If areas of concern are identified as a result of this review, the MCO is notified and corrective action is initiated and monitored through completion.

It has not been necessary to impose sanctions for inadequate networks because the MCOs have been responsive to all requests for network improvements or enhancements, especially covered services for women and children including child abuse services, early intervention services, pre-natal services, and special needs services. In the event that sanctions would be necessary for lack of performance by the MCOs, the following sanctions are identified in the contract between the MCOs and DMAS.

For each determination that the MCO fails to substantially provide medically necessary services to covered Medicaid enrollees through their network arrangements, a sanction of not more than $25,000 may be imposed on the MCO by DMAS. In addition, DMAS may:

1) **grant enrollees the right to terminate enrollment without cause;**
2) **suspend all new enrollment, including default enrollment, after the effective date of the sanction;**
3) **suspend payment for recipients enrolled after the effective date of the sanction; and**
4) **appoint temporary management for the MCO.**

11. Please explain how the distance and travel time to obtain services under the waiver will not be further or longer than prior to the waiver.

The enrollee always has a choice of at least two MCOs (two MCOs, or one MCO and the PCCM program). The distance traveled to a hospital before the waiver is the same distance traveled after the waiver if the enrollee chooses the MCO with their hospital of choice in the MCO network.

In urban areas, the MCOs with the most Medicaid enrollees have the same hospital network as in fee-for-service. In rural areas, the enrollees will be able to use the same hospital after the waiver as before the waiver if the enrollee chooses the MCO with their hospital of choice in the MCO network.

12. Please explain how the MCOs/PHPs will be required to enable enrollees to access providers.

Each MCO provides Medicaid enrollees a directory of their

providers. MCOs allow PCP changes upon request.

MCOs must provide a toll free telephone number for all enrollees to assist with any questions and/or PCP changes. TDD and translation services are also available.

All MCOs must allow for enrollee choice of family planning providers without a referral as well as direct access to OB/GYNs for examination and consultation without a referral for females age 13 and older.

All MCOs have an established process (both voice and written) where an enrollee can express dissatisfaction of any kind with the MCO or with a provider of care. All MCOs notify enrollees of their rights to express dissatisfaction to the Plan, the State Bureau of Insurance, and/or to DMAS at any time. All MCOs document and disclose the enrollee complaint/ grievance/ appeal process within the MCO to DMAS on a monthly basis.

DMAS contracts with an enrollment broker to assist all enrollees in the selection of a PCP and an MCO. The MCOs provide the broker with monthly listings of network providers.

b. Appointment Scheduling (Appointment scheduling means the time before an enrollee can acquire an appointment with his or her provider for both urgent and routine visits.) The State has established standards for appointment scheduling for MCO/PHP enrollee's access to the following. Check any that apply (1-9). For each item checked, please describe the standard and answer monitoring questions 10 and 11.

1. √ PCPs (please describe your standard):

The MCOs must arrange to provide care according to each of the following appointment standards:

a) Appointments for emergency services must be made available immediately upon the enrollee's request.

b) Appointments for an urgent medical condition must be made within twenty-four (24) hours of the enrollee's request.

c) Appointments for routine care must be made within thirty (30) calendar days of the enrollee's request. This standard does not apply to appointments for routine

physical examinations nor for regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequent than once every thirty (30) days.

2. _√_ Specialists (please describe your standard):

The MCOs must arrange to provide care according to each of the following appointment standards:

a) Appointments for emergency services must be made available immediately upon the enrollee's request.

b) Appointments for an urgent medical condition must be made within twenty-four (24) hours of the enrollee's request.

c) Appointments for routine care must be made within thirty (30) calendar days of the enrollee's request. This standard does not apply to appointments for routine physical examinations nor for regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently than once every thirty (30) days.

For maternity care, the MCO must be able to provide initial prenatal care appointments for pregnant enrollees as follows:

a) First trimester – within fourteen (14) calendar days of request

b) Second trimester – within seven (7) calendar days of request

c) Third trimester – within three (3) business days of request

Appointments must be scheduled for high-risk pregnancies within three (3) business days of identification of high risk to the MCO or maternity provider or immediately if an emergency exists.

3. _√_ Ancillary providers (please describe your standard):

Appointment scheduling standards for ancillary providers are identified by the type of medically necessary services needed:

a) For medically necessary emergency services that require

ancillary services, no appointment is needed.

b) For an urgent medical condition, the appointment must be within 24 hours of the request or PCP referral.

c) For routine care, the appointment must be made within thirty (30) calendar days of the request. PCP referral authorization is required for routine care. The routine care standard does not apply to ancillary services related to physical examinations or scheduled ancillary visits for chronic medical conditions that require less frequent appointments.

4.___ Pharmacies (please describe your standard):

DMAS contracts do not have appointment schedule standards applicable to pharmacies. Most of the major chains in the network have selected pharmacies open 24 hours a day.

5._√__Hospitals (please describe your standard):

Appointments with hospitals have standards identified by the type of medically necessary services needed:

a) For medically necessary emergency services, no appointment is necessary.

b) For an urgent medical condition, the appointment must be within twenty-four (24) hours of the request and authorized.

c) For routine care, the appointment must be made within thirty (30) calendar days of the request. PCP referral authorization is required for routine care. The routine care standard does not apply to physical examinations or scheduled visits for chronic medical conditions that require less frequent appointments.

6._√__ Mental Health (please describe your standard):

Appointments with mental health providers have standards identified by the type of medically necessary services needed:

a) For medically necessary emergency services, no appointment is necessary.

b) For an urgent medical condition, the appointment must be within twenty-four (24) hours of the request and authorized.

c) For routine care, the appointment must be made within thirty (30) calendar days of the request. PCP referral authorization is required for routine care. The routine care standard does not apply to visits for chronic mental health conditions that require less frequent appointments.

7.___ Substance Abuse Treatment Providers (please describe your standard):

8._√_ Dental (please describe your standard):

Appointments with dental providers have standards identified by the type of medically necessary dental services needed:

a) For medically necessary emergency services, no appointment is necessary.

b) For an urgent medical condition, the appointment must be within twenty-four (24) hours of the request and authorized.

c) For routine care, the appointment must be made within thirty (30) calendar days of the request. This standard does not apply to appointments for routine physical examinations, nor for regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently than once every thirty (30) days.

Even though the above is the standard, DMAS and the MCOs attempt to fully comply except where there are problems due to a shortage of dental providers. The Dental Advisory Committee (DAC) continues to address this issue. MCOs have the ability to utilize out-of-network dental providers whereas the fee-for-service program does not have this flexibility.

9.___ Other providers (please describe your standard):

10. Please explain how often and how the State monitors compliance and what incentives/sanctions/enforcement the State makes with each of the appointment scheduling standards checked above.

DMAS reviews complaints received from the MCOs, the enrollment broker, and the DMAS Helpline on a monthly basis.

For calendar year 2001, a review by DMAS shows that 170 out of 7,255 complaints were related to provider access to health services. This represents 2.3% of all complaints annually. (See Attachment B.I.b.10. for the Managed Care Complaint Reports for Calendar Years 2001 and 2002.) This category includes appointment scheduling as well as the following:

- **Geographic access limitations to providers and practitioners**
- **Availability of PCPs, specialists, and behavioral and mental health providers**
- **PCP after-hour access**
- **PCP phone availability during office hours (no answer, lengthy hold, busy)**
- **Access to urgent care and emergency care**
- **Out-of-network access**
- **Availability and timeliness of provider appointments and provision of services**
- **Availability of outpatient services within the network (Includes HHA, hospice, labs, physical therapy, radiation therapy)**
- **Enrollee provisions to allow transfers to other PCPs**
- **Patient abandonment by PCP**
- **Pharmaceuticals (based upon the patient's condition, the use of generic drugs versus brand name drugs)**
- **Access to preventive care (immunization, prenatal, sexually transmitted diseases, alcohol, cancer, coronary, smoking)**
- **Access to MCO complaint and grievance procedures**
- **MCO enrollee notification regarding changes in the Evidence of Coverage (EOC) and mandated benefits.**

All MCOs must have standards of performance for physician access and availability standards. The standards are based on appointment types (routine, urgent, emergency). A sample of an MCO's standards of performance is in Attachment B.I.b.10. Additionally, all but two MCO plans are NCQA or JCAHO accredited, and they must meet NCQA standards. Accordingly, provider performance with respect to appointment scheduling is monitored not only by DMAS but also by the national MCO accreditation program.

DMAS's bi-annual CAHPS survey queries recipients regarding appointment scheduling. An independent contractor conducts the survey, and the most recently reported one did not indicate problems with appointment scheduling. Refer to Attachment

B.I.b.10., "The 2001 Medicaid Managed Care Customer Satisfaction Survey" (CAHPS), which was prepared by Delmarva Foundation for Medical Care, Inc. in November 2001.

The MCOs conduct annual member satisfaction surveys that contain questions regarding physician access and availability. The MCOs publish the survey results and discuss the same with DMAS. This is usually done on an annual basis. In addition, DMAS requires that each MCO perform a Consumer Assessment of Health Plans Survey (CAHPS) and report the results within the timeframe set by DMAS, at least one time during the Medallion II waiver period. Please refer to Attachment B.I.b.10 for an MCO-conducted member satisfaction survey.

If any MCO fails to ensure appointment scheduling standards as agreed to and as defined in the contract, DMAS will first notify the MCO and will request a corrective action plan including time frames to correct. If the notification and corrective action plan does not correct the situation, then DMAS may:

a) Impose a financial penalty up to a limit of $25,000 per each determination,
b) Appoint temporary management,
c) Grant enrollees the right to terminate enrollment without cause,
d) Suspend all new enrollment, including default enrollment, after the effective date of the sanction, and
e) Suspend payment for recipients enrolled after the effective date of the sanction and until CMS or the State is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

11. Please explain how often and how the State assures that appointment scheduling time frames are not longer than the non-waiver appointment scheduling.

DMAS reviews complaints monthly for enrollee complaints regarding appointment scheduling. Medicaid covered services are closely monitored by the MCOs, the enrollment broker, and DMAS' Helpline for both provider performance and enrollee responsibilities. When these complaints are researched, the conclusions reached usually are related to administrative issues and are not significant. The issues appear to be the

same across all Medicaid programs, both waiver and non-waiver managed care and non-managed care programs.

DMAS conducts bi-annual CAHPS surveys. Subsequent to the collection of the data, an independent assessment is completed and published. This survey includes all Medicaid delivery programs: MCO, primary care case management (PCCM), and fee for service (FFS). The results are compared to identify any significant variation among the three programs.

Virginia Medicaid has not identified any significant problems or variations regarding the people it serves in both the waiver and non-waiver programs related to appointment scheduling.

c. In-Office Waiting Times: The State has established standards for in-office waiting times for MCO/PHP enrollee's access to the following. Check any that apply (1-9). For each item checked, please describe the standard and answer monitoring questions 10 and 11.

DMAS has no performance standards regarding in-office waiting times; however, each MCO contract states wait-time standards based on NCQA or JCAHO standards. Please refer to Attachment B.I.c. for a sample MCO wait-time schedule which is defined in an Evidence of Coverage (EOC)/member handbook.

1.___ PCPs (please describe your standard):

2.___ Specialists (please describe your standard):

3.___ Ancillary providers (please describe your standard):

4.___ Pharmacies (please describe your standard):

5.___ Hospitals (please describe your standard):

6.___ Mental Health (please describe your standard):

7.___ Substance Abuse Treatment Providers (please describe your standard):

8.___ Dental (please describe your standard):

9.__ Other providers (please describe your standard):

10. Please explain how often and how the State monitors compliance and what incentives/sanctions/enforcement the State makes with

each of the in-office waiting time standards checked above.

11. Please explain how the State assures that in-office waiting times are not longer than the non-waiver in-office waiting times.

II. Access and Availability Monitoring: Enrollee access to care will be monitored as part of each MCO/PHP's Internal Quality Assurance Plan (QAP), annual external quality review (EQR), periodic medical audits, or Independent Assessments (IA).

Previous Waiver Period

a.___ During the last waiver period, the access and availability monitoring was operated differently than described in the waiver governing that period. The differences were:

b.___ [Required for all elements checked in the previous waiver submittal] Please include the results from monitoring MCO/PHP access and availability in the previous two year period. [item B.II in the 1999 initial preprint; items B.4, 5, and 6 in the 1995 preprint].

For information on monitoring MCO access and availability, please refer to the 1st quarter provider network analysis in Attachment B.III.b.

Upcoming Waiver Period -- For items a. through o. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Check below any of the following (a-o) that the State will also utilize to monitor access:

a. √ Measurement of access to services during and after a MCO/PHP's regular office hours to assure 24 hour accessibility, 7 days a week (e.g., PCPs' 24-hour accessibility will be monitored through random calls to PCPs during regular and after office hours)

This is required in the PCPs' contracts with the MCOs. MCO PCP contracts are reviewed prior to MCO implementation and when changed or updated by the MCO. Monthly recipient complaints are monitored for compliance with this requirement. Historically, there have been few complaints regarding availability and access.

DMAS had the EQRO conduct a 24-hour access survey on MCO PCPs. The results can be found in Attachment B.II.a.

b. √ Determination of enrollee knowledge on the use of managed care programs

This is assessed in the surveys done by each MCO and DMAS as well as through the enrollment broker and community feedback.

c. √ Ensures that services are provided in a culturally competent manner to all enrollees.

This is assessed in the surveys done by each MCO and DMAS. DMAS requires the MCOs to publish and communicate enrollees' rights whenever appropriate.

DMAS approves all written materials used by the MCO prior to distribution to the enrollees and evaluates these materials for comprehension and readability. "Dignity and respect" are the typical words looked for in the documentation as well as implied in any enrollee correspondence. The complaint logs are also reviewed for any potential violations related to this requirement.

DMAS is sensitive to the increasingly different cultures throughout the state. The barrier of translation services is being addressed by the enrollment broker, by each MCO, and by DMAS through the recently revised/translated mailings.

d. √ Review of access to emergency or family planning services without prior authorization

DMAS ensures that this information is disclosed thoroughly in the Evidence of Coverage (EOC) and/or member handbook for each MCO. A review of the EOCs and/or member handbooks is performed annually. Participating providers of these types are checked for inclusion in the network. Enrollee surveys also contain questions for evaluating this requirement. DMAS also reviews provider and recipient complaints regarding access to these services.

e. √ Review of denials of referral requests

Most of the MCOs have greatly reduced their referral requirements. DMAS retains an EQRO to review medical records and patterns of care (under or over utilization) to ensure that enrollees are referred to a specialist when appropriate, medically necessary care is required. DMAS' complaint logs are also monitored for this criterion. DMAS tracks and reviews appeals upon receipt that are related to an MCO's provider refusing an enrollee a referral to a specialist. All MCOs have an expedited grievance and appeals process for serious illnesses.

f. √ Review of the number and/or frequency of visits to emergency rooms, non-authorized visits to specialists, etc., for medical care.

Each MCO monitors emergency room utilization for non-emergency situations as well as claims denied due to lack of authorization from PCPs.

g. √ Periodic enrollee experience surveys (which includes questions concerning the enrollees' access to all services covered under the waiver) will be mailed to a sample of enrollees. Corrective actions taken on deficiencies found are also planned.

Enrollee experience is assessed in the CAHPS surveys done by each MCO and DMAS. Corrective action plans are coordinated with the MCO's Quality Improvement Committee. This is the primary tool used to update, modify, or correct policies and procedures in both the MCOs' Quality Improvement Plan (QIP) and Utilization Management (UM) plans.

h. √ Measurement of enrollee requests for disenrollment from a MCO/PHP due to access issues

This is monitored monthly by DMAS' enrollment broker. In addition, DMAS has, uses, and promotes the use of a process called "disenrollment for good cause". Recipients have the right to request disenrollment from an MCO by simply submitting an oral or written request. A managed care specialist in DMAS' managed care division reviews good cause requests beyond the 90-day enrollment or 60-day open enrollment periods. Results of the review and decision made are communicated in writing to the recipient. These written responses include appeals rights.

i. √ Tracking of complaints/grievances concerning access issues

This is monitored monthly by four different sources for recipients enrolled in an MCO. The four sources are: DMAS' Helpline, DMAS' managed care database, the enrollment broker, and the MCOs' complaint logs. Please refer to Attachment B.I.b.10, Managed Care Complaints Reports – 2001 and 2002, for summary results.

j. √ Geographic Mapping detailing the provider network against beneficiary locations will be used to evaluation network adequacy. (Please explain)

DMAS does not currently prepare geographic mappings showing the provider networks compared to beneficiaries' locations. However,

the MCOs prepare mappings and provide copies to DMAS, upon request, of their geographic analyses comparing network providers to enrollee locations. See Attachment B.II.j. for a sample geographic mapping prepared by one of DMAS' contracted MCOs.

k. √ Monitoring access to prescriptions on the State Plan Formulary, Durable Medical Equipment, and therapies.

l. √ During monitoring, the State will look for the following indications of access problems.

1. √ Long waiting periods to obtain services from a PCP.
2. √ Denial of referral requests when enrollees believe referrals to specialists are medically necessary.
3. √ Confusion about how to obtain services not covered under the waiver.
4. √ Lack of access to services after PCP's regular office hours.
5. √ Inappropriate visits to emergency rooms, non-authorized visits to specialists, etc., for medical care.
6. √ Lack of access to emergency or family planning services.
7. √ Frequent recipient requests to change a specific PCP.
8. Other indications (please describe):

m. √ Monitoring the provision and payment for transportation for beneficiaries to get to their outpatient, medically necessary mental health services.

n. √ Monitoring the provider network showing that there will be providers within the distance/travel times standards.

o. Other (please explain):

III. Capacity Standards

Previous Waiver Period

a. During the last waiver period, the capacity standards were operated differently than described in the waiver governing that period. The differences were:

b. √ [Required] MCO/PHP Capacity Standards. The State ensured that the number of providers under the waiver remained approximately the same or increased compared to the number before the implementation of the waiver. Please describe the results of this monitoring.

Refer to the attached 1st Quarter Network Analyses in Attachment B.III.b and the Expansion Network Analyses in Attachment B.IV.b.

c._√_ [Required if elements III.a.1 and III.a.2 were marked in the previous waiver submittal] The State has monitored to ensure that enrollment limits and open panels were adequate and that provider capacity remained approximately the same or improved under the waiver. Please describe the results of this monitoring.

The State receives an MCO report monthly that describes a specific plan's enrollment and lists the number of available primary care providers, how many have open panels, closed panels, or restrictive panels. This report is reviewed and monitored monthly to ensure that recipients have access to a Primary Care Provider. Please refer to Attachment B.IV.b. for the Annual 2001 and 2002 CMS Reports.

Upcoming Waiver Period -- For items a. through c. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Please describe the capacity standards for the upcoming two year period.

a. MCO/PHP Capacity Standards

1._√_ The State has set enrollment limits for the MCO/PHPs. Please describe a) the enrollment limits and how each is determined and b) a description of how often and through what means the limits are monitored and changed.

The State has set enrollment limits of 70% in a two-or-more MCO locality. No current MCO plan has captured a monopoly of enrollment in any locality. The State has not had the need to limit enrollment of MCOs and does not anticipate the need to limit enrollment in the future.

Current and future MCOs that contract with DMAS must accept enrollment as determined and authorized by DMAS.

2._√_ The State monitors to ensure that there are adequate open panels within the MCO/PHP. Please describe how often and how the monitoring takes place.

The MCOs report quarterly to DMAS and monthly to the enrollment broker the number of PCPs that have open panels, closed panels, and restricted panels. An example of a restricted panel is a pediatrician who only manages the health needs of children under the age of 13. DMAS then compares these numbers to the number of enrollees to ensure that PCP ratios are met.

3. √ [Required] The State ensures that the number of providers under the waiver is expected to remain approximately the same or increase compared to the number before the implementation of the waiver. Please describe how the State will ensure that provider capacity will remain approximately the same or improve under the waiver.

The traditional Medicaid network is identified and quantified routinely by provider class and geographical area. MCOs must develop and credential their networks to meet their enrollment needs and ensure the delivery of medically necessary services as well as ensure coordination with and referral to community based providers.

Many of the MCO networks serve the commercial population in their approved areas as well as the Medicaid enrollees in their MCO. These MCO combined networks continue to expand to meet the needs of managed care waiver enrollees. All MCO networks, including hospitals, PCPs, and specialists, are reviewed by DMAS and meet or exceed contract requirements.

4. √ [Required] For all provider types in the program, list in the chart below for each geographic area(s) applicable to your State, the number of providers before the waiver, during the current waiver period and the number projected for the proposed renewal period. **Please provide a definition of your geographic area,** i.e. by county, region or capitated rate area. Please complete only for the providers included in your waiver program.

For risk-comprehensive programs, please modify to reflect your State's program and complete the following chart:

The State has been divided into eight managed care regions. A map outlining these regions is provided in Attachment B.III.a.4. The regions are:

- **Region 1A Tidewater**
- **Region 1B Central Virginia**
- **Region 2 Northern Virginia**
- **Region 3 Alleghany/Winchester**
- **Region 4 Charlottesville**
- **Region 5 Far Southwest Virginia**
- **Region 6 Roanoke**
- **Region 7 Halifax**
- **Region 8 Lynchburg**

In Regions 1A, 1B, 4, and part of Region 7, the Medallion II program operates with

2 or more contracted managed care organizations. In Regions 2, 6, and the rest of Region 7, the Medallion II program operates with the MEDALLION PCCM program. In Regions 3, 5, and 8, the MEDALLION PCCM program is the only operational program.

****Following are charts for each MCO in the Medallion II network which describe their network composition. An explanation of the network counts follows each chart. Please note in the column labeled "# Before the Waiver", the numbers shown reflect the number of anticipated providers as determined from the evaluation of RFP responses prior to the most recent Medallion II expansion which occurred in December 2001. Provider numbers prior to this are not available since our system does not capture old provider enrollment data. This information also was not required for previous waivers. Therefore, we are unable to provide numbers prior to the last expansion.**

Southern Health Services / Care *N*et is the smallest MCO in Virginia. As of September 2002, they had 12,637 recipients enrolled in Medallion II.

One Region: Region 1B – Central Virginia

Providers	# Before the ~~Waiver~~ **Expansion**	# In Current Waiver	# Expected in Renewal
FQHCs		**Region 1B: N/A**	**Region 1B: N/A**
Hospitals		**Region 1B: 12**	**Region 1B: 12**
Pharmacies		**Region 1B: 81**	**Region 1B: 81**
Primary Care Providers (Please specify) - Family Practice - Internal Medicine - OB/GYNs - Pediatricians - Physician Extenders		**Region 1B: 169** **Region 1B: 119** **Region 1B: 148** **Region 1B: 123**	**Region 1B: 169** **Region 1B: 119** **Region 1B: 148** **Region 1B: 123**
Other (please specify) - General Practice		**Region 1B: 30**	**Region 1B: 30**

*Please note any limitations to the data in the chart above here:

This plan has FQHC providers in its network; however, they are not identified uniquely as such in the provider files. FQHC providers may include PCPs, OB/GYNs, Nurse Practitioners, and/or Physician Assistants.

<u>Sentara Family Care</u> has the greatest number of recipients. As of September 2002, Sentara had 84,398 recipients enrolled in Medallion II.

Four Regions: **Region 1A – Tidewater** **Region 4 - Charlottesville**
Region 1B – Central Virginia **Region 7 - Halifax**

Providers	# Before the ~~Waiver~~ **Expansion**	# In Current Waiver	# Expected in Renewal
FQHCs	**Region 4: 40** **Region 7: 0**	**Region 1A: 20** **Region 1B: 57** **Region 4: 40** **Region 7: 0**	**Region 1A: 20** **Region 1B: 57** **Region 4: 40** **Region 7: 0**
Hospitals	**Region 4: 3** **Region 7: 2**	**Region 1A: 13** **Region 1B: 25** **Region 4: 5** **Region 7: 2**	**Region 1A: 13** **Region 1B: 25** **Region 4: 5** **Region 7: 2**
Pharmacies	**Region 4: 29** **Region 7: 32**	**Region 1A: 208** **Region 1B: 301** **Region 4: 50** **Region 7: 13**	**Region 1A: 208** **Region 1B: 301** **Region 4: 50** **Region 7: 13**
Primary Care Providers (Please specify) - Family Practice	**Region 4: 68** **Region 7: 17**	**Region 1A: 282** **Region 1B: 216** **Region 4: 146** **Region 7: 23**	**Region 1A: 282** **Region 1B: 216** **Region 4: 146** **Region 7: 23**
- Internal Medicine	**Region 4: 75** **Region 7: 13**	**Region 1A: 214** **Region 1B: 228** **Region 4: 97** **Region 7: 20**	**Region 1A: 214** **Region 1B: 228** **Region 4: 97** **Region 7: 20**
- OB/GYNs	**Region 4: 34** **Region 7: 9**	**Region 1A: 240** **Region 1B: 160** **Region 4: 36** **Region 7: 8**	**Region 1A: 240** **Region 1B: 160** **Region 4: 36** **Region 7: 8**

Providers	# Before the ~~Waiver~~ **Expansion**	# In Current Waiver	# Expected in Renewal
- Pediatricians - Physician Extenders	**Region 4: 51** **Region 7: 9**	**Region 1A: 260** **Region 1B: 150** **Region 4: 69** **Region 7: 12**	**Region 1A: 260** **Region 1B: 150** **Region 4: 69** **Region 7: 12**
Other (please specify)			

- Please note any limitations to the data in the chart above here:

<u>UNICARE Health Plan of Virginia</u> is the newest MCO to contract with Virginia Medicaid. Recipient enrollment began in December 2001. UNICARE is the second smallest MCO in Virginia. As of September 2002, UNICARE had 29,373 recipients enrolled in Medallion II.

Two Regions: Region 2 – Northern Virginia Region 4 - Charlottesville

Providers	# Before the ~~Waiver~~ **Expansion**	# In Current Waiver	# Expected in Renewal
FQHCs	**Region 2: N/A** **Region 4: N/A**	**Region 2: N/A** **Region 4: N/A**	**Region 2: N/A** **Region 4: N/A**
Hospitals	**Region 2: 11** **Region 4: 1**	**Region 2: 11** **Region 4: 1**	**Region 2: 11** **Region 4: 1**
Pharmacies	**Region 2: 276** **Region 4: 33**	**Region 2: 277** **Region 4: 32**	**Region 2: 277** **Region 4: 32**
Primary Care Providers (Please specify) - Family Practice - Internal Medicine	 **Region 2: 85** **Region 4: 54** **Region 2: 119** **Region 4: 51**	 **Region 2: 88** **Region 4: 54** **Region 2: 130** **Region 4: 50**	 **Region 2: 88** **Region 4: 54** **Region 2: 130** **Region 4: 50**

Providers	# Before the ~~Waiver~~ **Expansion**	# In Current Waiver	# Expected in Renewal
- OB/GYNs	**Region 2: 87** **Region 4: 46**	**Region 2: 127** **Region 4: 51**	**Region 2: 127** **Region 4: 51**
- Pediatricians	**Region 2: 206** **Region 4: 55**	**Region 2: 215** **Region 4: 57**	**Region 2: 215** **Region 4: 57**
- Physician Extenders			
Other (please specify) - General Practice	**Region 2: 21** **Region 4: 0**	**Region 2: 25** **Region 4: 2**	**Region 2: 25** **Region 4: 2**

* Please note any limitations to the data in the chart above here:

This plan has developed a strong FQHC network; however, they are not identified uniquely as such in the provider files. FQHC providers may include PCPs, OB/GYNs, Nurse Practitioners, and/or Physician Assistants.

<u>Virginia Premier Health Plan</u> is the second largest MCO in Virginia. As of September 2002, they had 60,102 recipients enrolled in Medallion II.

Five Regions: **Region 1A – Tidewater** **Region 4 – Charlottesville**
Region 1B – Central Virginia **Region 7 - Halifax**
Region 2 – Northern Virginia

Providers	# Before the ~~Waiver~~ **Expansion**	# In Current Waiver	# Expected in Renewal
FQHCs	**Region 2: N/A** **Region 4: N/A** **Region 6: N/A**	**Region 1A: N/A** **Region 1B: N/A** **Region 2: N/A** **Region 4: N/A** **Region 6: N/A**	**Region 1A: N/A** **Region 1B: N/A** **Region 2: N/A** **Region 4: N/A** **Region 6: N/A**
Hospitals	**Region 2: 2** **Region 4: 2** **Region 6: 13**	**Region 1A: 7** **Region 1B: 15** **Region 2: 2** **Region 4: 2** **Region 6: 13**	**Region 1A: 7** **Region 1B: 15** **Region 2: 2** **Region 4: 2** **Region 6: 13**

Providers	# Before the ~~Waiver~~ **Expansion**	# In Current Waiver	# Expected in Renewal
Pharmacies	**Region 2: 5** **Region 4: 89** **Region 6: 152**	**Region 1A: 257** **Region 1B: 314** **Region 2: 11** **Region 4: 73** **Region 6: 155**	**Region 1A: 257** **Region 1B: 314** **Region 2: 11** **Region 4: 73** **Region 6: 155**
Primary Care Providers (Please specify) - Family Practice	**Region 2: 4** **Region 4: 94** **Region 6: 197**	**Region 1A: 53** **Region 1B: 104** **Region 2: 4** **Region 4: 138** **Region 6: 182**	**Region 1A: 53** **Region 1B: 104** **Region 2: 4** **Region 4: 138** **Region 6: 182**
- Internal Medicine	**Region 2: 4** **Region 4: 83** **Region 6: 86**	**Region 1A: 66** **Region 1B: 162** **Region 2: 4** **Region 4: 220** **Region 6: 107**	**Region 1A: 66** **Region 1B: 162** **Region 2: 4** **Region 4: 220** **Region 6: 107**
- OB/GYNs	**Region 2: 3** **Region 4: 32** **Region 6: 64**	**Region 1A: 121** **Region 1B: 89** **Region 2: 3** **Region 4: 69** **Region 6: 50**	**Region 1A: 121** **Region 1B: 89** **Region 2: 3** **Region 4: 69** **Region 6: 50**
- Pediatricians	**Region 2: 3** **Region 4: 55** **Region 6: 58**	**Region 1A: 130** **Region 1B: 132** **Region 2: 6** **Region 4: 151** **Region 6: 61**	**Region 1A: 130** **Region 1B: 132** **Region 4: 151** **Region 7: 61**
- Physician Extenders			
Other (please specify) - General Practice	**Region 2: 1** **Region 4: 6** **Region 6: 5**	**Region 1A: 2** **Region 1B: 0** **Region 2: 1**	**Region 1A: 2** **Region 1B: 0** **Region 2: 1**

Providers	# Before the ~~Waiver~~ Expansion	# In Current Waiver	# Expected in Renewal
		Region 4: 6 **Region 6: 2**	**Region 4: 6** **Region 6: 2**

*Please note any limitations to the data in the chart above here:

This plan has developed a strong FQHC network; however, they are not identified uniquely as such in the provider files. FQHC providers may include PCPs, OB/GYNs, Nurse Practitioners, and/or Physician Assistants.

<u>Trigon HealthKeepers</u> is the third largest MCO in Virginia. As of September 2002, they had 58,783 recipients enrolled in Medallion II.

Three Regions: Region 1A – Tidewater Region 7 – Halifax
Region 1B - Central Virginia

Providers	# Before the ~~Waiver~~ Expansion	# In Current Waiver	# Expected in Renewal
FQHCs	**Region 7: N/A**	**Region 1A: N/A** **Region 1B: N/A** **Region 7: N/A**	**Region 1A: N/A** **Region 1B: N/A** **Region 7: N/A**
Hospitals	**Region 7: 1**	**Region 1A: 15** **Region 1B: 21** **Region 7: 1**	**Region 1A: 15** **Region 1B: 21** **Region 7: 1**
Pharmacies	**Region 7: 37**	**Region 1A: 315** **Region 1B: 371** **Region 7: 37**	**Region 1A: 315** **Region 1B: 371** **Region 7: 37**
Primary Care Providers (Please specify) - Family Practice - Internal Medicine	 **Region 7: 5** **Region 7: 5**	 **Region 1A: 299** **Region 1B: 200** **Region 7: 5** **Region 1A: 198** **Region 1B: 194** **Region 7: 5**	 **Region 1A: 299** **Region 1B: 200** **Region 7: 5** **Region 1A: 198** **Region 1B: 194** **Region 7: 5**

Providers	# Before the ~~Waiver~~ **Expansion**	# In Current Waiver	# Expected in Renewal
- OB/GYNs - Pediatricians - Physician Extenders	**Region 7: 5** **Region 7: 4**	**Region 1A: 157** **Region 1B: 227** **Region 7: 5** **Region 1A: 269** **Region 1B: 168** **Region 7: 4**	**Region 1A: 157** **Region 1B: 227** **Region 7: 5** **Region 1A: 269** **Region 1B: 168** **Region 7: 4**
Other (please specify) - General Practice	**Region 7: 3**	**Region 1A: 41** **Region 1B: 26** **Region 7: 3**	**Region 1A: 41** **Region 1B: 26** **Region 7: 3**

*Please note any limitations to the data in the chart above here:

This plan has developed a strong FQHC network; however, they are not identified uniquely as such in the provider files. Providers may include PCPs, OB/GYNs, nurse practitioners, and/or physician assistants.

For other risk programs, please modify for your State's program and complete the following chart: **Not Applicable**

Providers	# Before the Waiver	# In Current Waiver	# Expected in Renewal
Developmental Disabilities Providers (please specify)			
Hospitals			
Mental Health Providers (please specify)			
Pharmacies			
Substance Abuse Treatment & Rehab Providers (please specify)			

Providers	# Before the Waiver	# In Current Waiver	# Expected in Renewal
Transportation Providers (please specify)			
Vision Providers			
Other (please specify)			

*Please note any limitations to the data in the chart above here:

b. PCP Capacity Standards

1. The State has set capacity standards for PCPs within the MCOs/PHP expressed in the following terms (In the case of a PHP, a PCP may be defined as a case manager or gatekeeper):

   i. √ PCP to enrollee ratio
   ii. √ Maximum PCP capacity
   iii. √ For PCP contracts with multiple plans, please describe any efforts the State is making to monitor unduplicated Medicaid enrollment capacity across plans?

   As for efforts to monitor unduplicated Medicaid enrollment capacity, DMAS monitors and tracks each MCO individually. DMAS requires each MCO to provide PCPs for all enrollees. DMAS reserves the right to restrict new enrollments to an MCO that has no available panel slots.

2. √ The State ensures adequate geographic distribution of PCPs within MCO/PHPs. Please explain.

   This is primarily the responsibility of each MCO for their Medicaid MCO population. The State monitors adequacy through network analyses and complaints related to access regarding distance. The MCOs know the importance of adequate geographic PCP distribution which may include the need for network expansion, when appropriate.

3. √ The State designates the type of providers that can serve as PCPs. Please list these provider types.

   Family Practice/Medicine

General Practice/Medicine
Internal Medicine
Pediatric
Specialists as approved and operating within the scope of their licenses

c. Specialist Capacity Standards

1.___ The State has set capacity standards for specialty services. Please explain.

DMAS does not have capacity standards for specialty services. DMAS' MCO contract requires a comprehensive specialist network to provide medically necessary services for any and all covered Medicaid services. In the event that a specialist is needed that is not in the MCO network, the MCO must make arrangements to deliver the medically necessary services out-of-network.

Most of the MCOs have a very mature, comprehensive specialist network developed. DMAS reviews the network analyses and monitors complaints from recipients related to access and availability concerns for specialist access and referral restrictions.

The MCO is encouraged to develop and maintain a list of referral sources which includes community agencies, state agencies, "safety net" providers, teaching institutions, and facilities that are needed to ensure that the enrollees are able to access and receive the full continuum of treatment and rehabilitative medical and outpatient mental health services and supports.

2.√** The State monitors access to specialty services. Please explain how often and how monitoring is done.

Most of the MCOs have a very mature, comprehensive specialist network developed. DMAS reviews network analyses and monitors complaints from recipients related to access and availability concerns for specialist access and referral restrictions.

In error, this item was not checked in the previous waiver.

3.___ The State requires particular specialist types to be included in the

MCO/PHP network. Please identify these in the chart below, modifying the chart as necessary to reflect the specialists in your State's waiver. Please describe the standard if applicable, e.g. speciality to enrollee ratio. If specialists types are not involved in the MCO/PHP network, please describe how arrangements are made for enrollees to access these services (for waiver covered services only).

DMAS does not have capacity standards for specialty services. DMAS' MCO contract requires a comprehensive specialist network to provide medically necessary services for any and all covered Medicaid services. In the event that a specialist is needed that is not in the MCO network, the MCO must make arrangements to deliver the medically necessary services out-of-network. The DMAS contract requires that the MCO maintain in its network and in its referral listing a number of specialists in the following specialties to its Medallion II enrollees:

Specialist Provider Type	Adult	Pediatric	Standards
Addictionologist and/or Certified Addition Counselors			
Allergist/Immunologist	**X**	**X**	
Cardiologist	**X**	**X**	
Chiropractors			
Dentist	**X**	**X**	**2,000 enrollees under age 21 per dental team**
Dermatologist	**X**	**X**	
Emergency Medicine Specialist	**X**	**X**	
Endocrinologist	**X**	**X**	
Gastroenterologist	**X**	**X**	
Hematologist	**X**	**X**	
Infectious/Parasitic Disease Specialist	**X**	**X**	
Neurologist	**X**	**X**	
Obstetrician/Gynecologist	**X**		
Oncologist	**X**	**X**	

Ophthalmologist	**X**	**X**	
Orthopedic Specialist	**X**	**X**	
Otolaryngologist	**X**	**X**	
Pediatrician		**X**	**1 FTE per 2,500 enrollees < age 18**
Psychiatrist	**X**	**X**	
Pulmonologist	**X**	**X**	
Radiologist	**X**	**X**	
Surgeon (General)	**X**	**X**	
Surgeon (Specialty)			
- Colon/Rectal Surgeon	**X**	**X**	
- Neurological Surgeon	**X**	**X**	
- Oral Surgeon	**X**	**X**	
- Plastic Surgeon	**X**	**X**	
- Thoracic Surgeon	**X**	**X**	
Other mental health providers (please specifiy):			
- Child Psychiatrist		**X**	
- Psychologist	**X**	**X**	
Other dental providers (please specify):			
- Periodontist	**X**	**X**	
Other (please specify)			
- Adolescent Medicine		**X**	
- Anesthesiologist	**X**	**X**	
- Genetics/Metabolism	**X**	**X**	
- Internal Medicine	**X**	**X**	
- Neonatal/Perinatal Medicine		**X**	
- Nephrologist	**X**	**X**	
- Pediatric Physical Medi-Cine and Rehabilitation		**X**	
- Pediatric Subspecialist		**X**	
- Physical Medicine/ Rehabilitation	**X**	**X**	
- Preventive Medicine	**X**	**X**	

- Rheumatologist	**X**	**X**	
- Urologist	**X**	**X**	

IV. Capacity Monitoring

Previous Waiver Period

a.___ During the last waiver period, the capacity monitoring was operated differently than described in the waiver governing that period. The differences were:

b. √ [Required for all elements checked in the previous waiver submittal] Please include the results from monitoring the MCO/PHP capacity in the previous two year period [item B.IV in the 1999 initial preprint; items A.15-16 in the 1995 preprint].

Quarterly network analyses were performed to ensure compliance with the number and types of Medicaid providers before and after the waiver and the provider-to-enrollee ratios. Each MCO was required to submit their complete provider network on a quarterly basis. In addition, each MCO submitted on a monthly basis a log of their grievances and appeals in order to ensure that access to care is not hindered for any reason.

The following reports are the results from monitoring MCO capacity in the previous two year period. See Attachments B.IV.b.:

- **Annual 2001 CMS Report (Virginia Medicaid MCO Information)**
- **Annual 2002 CMS Report (Virginia Medicaid MCO Information)**
- **Expansion Network Analysis**
- **Annual Monitoring Report - 2001**
- **1st Quarter Network Analysis (Attachment B.III.b.)**

Also refer to Attachment B.I.b.10. for the Annual 2001 and 2002 Managed Care Complaints Reports.

Upcoming Waiver Period -- For items a. through l. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response.
Please indicate which of the following activities the State employs:

a. √ Periodic comparison of the number and types of Medicaid providers before and after the waiver.

b.___ Measurement of referral rates to specialists.

c._√_ Provider-to-enrollee ratios

d._√_Periodic MCO/PHP reports on provider network

e._√_ Measurement of enrollee requests for disenrollment from a plan due to capacity issues

f._√_Tracking of complaints/grievances concerning capacity issues

g.___ Geographic Mapping (please explain)

i._√_ Tracking of termination rates of PCPs

j._√_ Review of reasons for PCP termination

k._√_ Consumer Experience Survey, including persons with special needs,

l.__ Other (Please explain):

V. Continuity and Coordination of Care Standards

Previous Waiver Period

a.___ During the last waiver period, the continuity and coordination of care standards were operated differently than described in the waiver governing that period. The differences were:

Upcoming Waiver Period -- For items a. through h. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Check any of the following that the State requires of the MCO/PHP:

a._√_Each enrollee selects or is assigned to a primary care provider appropriate to the enrollee's needs

When the recipient contacts the enrollment broker to confirm or change his MCO selection, the enrollment broker at that time completes a Health Status Assessment Form. This identifies any special health care needs of the recipient which will facilitate the enrollment broker's assignment to the most appropriate PCP.

b._√_ Each enrollee selects or is assigned to a designated health care practitioner who is primarily responsible for coordinating the enrollee's overall health care.

c. √ Health education/promotion. Please explain.

As stipulated in the Medallion II contract, health education is required under ESPDT. In addition, the MCO must develop, administer, implement, monitor, and evaluate a program to promote health education services. The MCO must maintain a written plan for health education and prevention that is based on the needs of its enrollees. The MCO will be responsible for developing and maintaining enrollee education programs designed to provide the enrollee with clear, concise, and accurate information about the MCO's health plan.

d. √ Each provider maintains, for Medicaid enrollees, health records that meet the requirements established by the MCO/PHP, taking into account professional standards

e. √ There is appropriate and confidential exchange of information among providers.

f. √ Informs enrollees of specific health conditions that require follow-up and, if appropriate, provides training in self-care

g. √ Deals with factors that hinder enrollee compliance with prescribed treatments or regimens.

h. √ Case management (please define your case management programs)

The State Plan requires case management services to be provided for high risk pregnant women and children under two years of age. In addition to the above required services, the MCOs also provide coordination of services for other special needs populations to minimize fragmentation of care, reduce barriers, and link enrollees with appropriate services to ensure comprehensive, continuous health care. The MCOs must also provide case management services for infants in neonatal intensive care.

VI. Continuity and Coordination of Care Monitoring

Previous Waiver Period

a. √ During the last waiver period, the continuity and coordination of care monitoring was operated differently than described in the waiver governing that period. The differences were:

In addition to supplying the plans with information identifying and tracking SSI and Title V (information which is also sent monthly to

CMS), DMAS now also identifies to the plans recipients on atypical medications, recipients who have been prior authorized by DMAS for transplantation surgeries or other special procedures, recipients who are pregnant at the time of Medicaid eligibility, and recipients identified with other special needs who may benefit from the services of a case manager to assist in the continuity and coordination of care services.

b. √ [Required for all elements checked in the previous waiver submittal] Please include the results from monitoring continuity and coordination of care in the previous two year period [item B.VI in the 1999 initial preprint; Section B (as applicable) in 1995 preprint].

These annual monitoring activities and reports are done internally within DMAS. The Annual Monitoring Report for 2001 may be found in Attachment B.IV.b.

c. √ [Required for all elements checked in the previous waiver submittal] Please describe any continuity or coordination of care requirements (i.e., information sharing requirements or any efforts that the State has required to avoid duplication of services) with these entities that the State required during the previous waiver period for the entities marked in B.VI in the previous waiver submission. These requirements do not include monitoring efforts.

The MCOs are contractually required to have systems in place to ensure coordinated patient care. The systems, policies, and procedures of the MCOs have been consistent with the most recent NCQA standards.

d. ___ [Required for all elements checked in the previous waiver submittal if this is a PHP mental health, substance abuse, or developmentally disabled population waiver] Please describe the State's efforts during the previous waiver period to ensure that primary care providers in FFS, PCCM or MCO programs and PHP providers are educated about how to detect MH/SA problems for both children and adults and where to refer clients once the problems are identified. Please describe the requirements for coordination between FFS, PCCM, or MCO providers and PHP providers. Please describe how this issue is being addressed in the PHP program.

e. ___ [Required if this is a PHP mental health, substance abuse, or developmentally disabled population waiver] Please describe how pharmacy services prescribed to program enrollees are monitored in this waiver program. In addition, please note if pharmacy services are not covered under this program.

Upcoming Waiver Period -- For items a. through c. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Please describe how standards for continuity and coordinations of care will be monitored in the upcoming two year period.

a. How often and through what means does the State monitor the coordination standards checked above?

Contract compliance is monitored monthly, quarterly, and annually by DMAS.

1. **Section B.V.a. (each enrollee selects or is assigned to a primary care provider) and Section B.V.b. (each enrollee selects or is assigned to a designated health care practitioner who is primarily responsible for coordinating the enrollee's overall health care) are monitored through monthly complaint reports received by DMAS as well as through on-site visits to all contracting MCOs. These visits were anticipated to be completed annually at the time of the last waiver renewal; however, they are being done bi-annually at this time.**

2. **Section B.V.c (health education/promotion) is monitored through the health education plans that each contracted MCO is required to submit to DMAS annually for review and approval. Each contracted MCO also participates in health fairs and health screening activities several times each year.**

3. **Section B.V.d (maintenance of health records that meet established requirements), Section B.V.e. (appropriate and confidential exchange of information among providers), and Section B.V.f. (informs enrollees of specific health conditions that require follow-up and, if appropriate, provides training in self-care) are essential elements in contract compliance which DMAS monitors annually. DMAS requires that participating MCOs receive NCQA and/or JCAHO accreditation. DMAS monitors medical records review requirements through the NCQA/JCAHO accreditation process.**

4. **Section B.V.g. (factors that hinder enrollee compliance with prescribed treatments or regiments) and Section B.V.h. (case management programs): DMAS monitors case management services which are a part of each contracted MCO. The case management component helps to manage service utilization for special needs populations while promoting comprehensive,**

continuous health care, minimizing fragmentation of care, and reducing barriers to compliance. Case management services are required for high risk pregnant women, children under two years of age, and infants in neonatal intensive care. Case management services are monitored through the surveys and quality assessments conducted by both DMAS and by each MCO as well as through periodic case management meetings which DMAS holds throughout the state.

b. Specify below any providers (which are excluded from the capitated waiver) that the State explicitly requires the MCO/PHP to coordinate health care services excluded from the capitated waiver with:

1. _√_ Mental Health Providers (please describe how the State ensures coordination exists):

   Mental health services are excluded in the contract; however, Community Service Boards provide intensive mental health services, and MCOs are required to coordinate other necessary services such as prescription drugs and transportation.

2. _√_ Substance Abuse Providers (please describe how the State ensures coordination exists):

   As stipulated in the Medallion II contract, the MCO must have in place written policies and procedures related to the coordination of substance abuse treatment services with other providers and a mechanism whereby enrollees seeking or needing these services may obtain them from the MCO.

3. _√**_ Local Health Departments (please describe how the State ensures coordination exists):

   MCOs must also work with local health departments in the coordination of immunizations.

4. ___ Dental Providers (please describe how the State ensures coordination exists):

5. ___ Transportation Providers (please describe how the State ensures coordination exists):

6. _√_ HCBS (1915c) Service (please describe how the State ensures coordination exists):

The MCOs are contractually required to have systems in place to ensure coordinated patient care. The systems, policies, and procedures must be consistent with the most recent NCQA standards. Through their managed care efforts, they assist recipients in receiving the services necessary until they are approved in a waiver program. The MCOs also assist recipients in completing forms necessary for waiver programs.

7.___ Developmental Disabilities (please describe how the State ensures coordination exists):

8.___ Title V Providers (please describe how the State ensures coordination exists):

9._√_ Women, Infants and Children (WIC) program

As stipulated in the Medallion II contract, the MCO must provide for the referral of potentially eligible women, infants, and children to the WIC program.

10.__ Indian Health Services providers

11._√_ FQHCs and RHCs not included in the program's networks

All FQHCs and RHCs are included in the MCO networks.

12.____Other (please describe):

Section C. QUALITY OF CARE AND SERVICES

A Section 1915(b) waiver program may not substantially impair enrollee access to medically necessary services of adequate quality. In addition, 1915(b) waiver programs which utilize MCOs or PHPs must meet certain statutory or regulatory requirements addressing quality of health care. This section of the waiver submittal will document how the State has monitored and plans to meet these requirements.

I. Elements of State Quality Strategies: -- This section provides the State the opportunity to describe the specifications it has implemented to ensure the delivery of quality services. To the extent appropriate, the specifications address quality considerations and activities for special needs populations.

Previous Waiver Period

a.___ During the last waiver period, the Elements of State Quality Strategies were different than described in the waiver governing that period. The differences were:

b. √ [Required] Describe the results of monitoring MCO/PHP adherence to State standards for internal Quality Assurance Programs during the previous two-year period [item C.I.b in 1999 initial preprint; Item B.1 in 1995 preprint].

All of the MCOs complied with State standards for internal Quality Assurance Programs (QAPs) and submitted required reports in compliance with specified timelines. Each MCO submitted a comprehensive Quality Improvement Program (QIP) that included the elements required by the State such as addressing quality of clinical care, access, continuity of care, utilization management, oversight, monitoring of complaints, development and review of treatment guidelines, credentialing, and re-credentialing.

Each MCO's written QAP was reviewed and approved prior to the State's execution of the contract. The QAP of each MCO is also reviewed annually, and to date, all have been found to meet State standards. Biannual on-site monitoring of MCO administrative offices occurred in May and June 2002. Results are reflected in Attachment C.I.b., "2002 Quality Review of Managed Care Organizations". Monitoring activities were conducted by the State's Medicaid agency personnel and by non-state agency contractors. Keystone Peer Review Organization, Inc. and George Mason University were the contractors for the first half of the waiver period, and Delmarva Foundation, Inc. is the current contractor.

c. √ [Required for MCOs] Summarize the results of reports from the External Quality Review Organization. Describe any follow-up done/planned to address study findings [item C.I.c in 1999 initial preprint; item B.2 in 1995 preprint].

1. **Encounter Data Validation Study**
   Keystone Peer Review Organization, Inc. conducted an encounter data validation study in 2001 to determine the completeness and accuracy of encounter data. The analysis was performed at the recipient level with separate samples drawn from each managed care organization (MCO). Recommendations from the study included enhancing the State's information system and provider file. Enhancements to the provider file are built into the new MMIS specifications. See Attachment C.I.c.1. for a copy of the study which was submitted in May 2001.

2. **Consumer Assessment of Health Plans Survey (CAHPS)**
   During the fall of 2001, Delmarva Foundation, Inc., through its subcontractor, WB&A Market Research, performed a CAHPS survey. The CAHPS ® 2.0 Medicaid Managed Care and Fee-For-Service surveys were used. Supplemental questions were included pertaining to children's health care, chronic conditions, utilization of services, interpreter services as well as transportation, health care, prescription, dental, specialist, and pregnancy services. Following are some findings from the report; however, please see Attachment B.I.b.10. for a copy of the complete report.

Overall Ratings - Percent of respondents who gave a rating of 9 or 10 on a scale of 0 – 10, with 10 being best:

	MED Adult	Med II Adult	MED Child	Med II Child	MED SSI/Title V	Med II SSI/Title V
Personal Doctor	65%	71%	69%	65%	70%	75%
Specialist	71%	67%	65%	69%	68%	79%
Quality of Care	67%	65%	73%	69%	73%	74%
Health Plan	65%	64%	74%	63%	71%	62%

Getting Needed Care - Percent of respondents who said they had no problems getting needed care:

	MEDALLION	Medallion II
Adult	79%	82%

Child	85%	84%
SSI/Title V	85%	88%

<u>Getting Care Quickly</u> - Percent of respondents who said they always got care quickly:

	MEDALLION	Medallion II
Adult	57%	57%
Child	63%	61%
SSI/Title V	66%	64%

<u>How Well Doctors Communicate</u> - Percent of respondents who said doctors always communicated well:

	MEDALLION	Medallion II
Adult	71%	71%
Child	77%	76%
SSI/Title V	78%	78%

<u>Courteous & Helpful Office Staff</u> - Percent of respondents who said staff were always courteous & helpful:

	MEDALLION	Medallion II
Adult	78%	78%
Child	79%	78%
SSI/Title V	85%	82%

<u>Health Plan's Customer Service</u> - Percent of respondents who said they had no problems getting help:

	MEDALLION	Medallion II
Adult	57%	73%
Child	70%	74%
SSI/Title V	77%	72%

Percent of respondents who said they had no problem getting special equipment:

	MEDALLION	Medallion II
Adult	73%	78%
Child	62%	64%
SSI/Title V	57%	56%

Percent of respondents who said they had no problems getting home health care:

	MEDALLION	Medallion II
Adult	61%	77%
Child	86%	67%

SSI/Title V	50%	62%

3. **<u>Twenty-Four Hour, Seven Day Telephone Access</u>**
   In the winter of 2001 - 2002, Delmarva Foundation, Inc. conducted a telephone survey of a sample of primary care providers (PCPs) in the Medallion II program to determine compliance with the State's requirements to provide telephone access twenty-four hours per day, seven days per week. The External Quality Review Organization (EQRO) concluded that, in general, providers met the Medallion II program accessibility requirements reasonably well. The Medallion II MCOs were given lists of providers to investigate phone numbers that were invalid. MCOs were asked to reinforce the standards with all Medallion II primary care physicians. Please see Attachment B.II.a. for a copy of the report.

d. √ [Required for PHPs and MCOs] Describe the results of periodic medical audits, and any follow-up done/planned to address audit findings [item C.I.d in 1999 initial preprint; item B.3 in 1995 preprint].

<u>Pediatric Asthma</u> – The results of a pediatric asthma study were received in Spring 2002. This study examined the utilization of emergency room services and inpatient hospitalizations for children aged two through twenty years who had a diagnostic mention of asthma. The children were recipients in either the MEDALLION, Medallion II, or Fee-for-Service Medicaid programs during State Fiscal Year 2000 (July 1, 1999 through June 30, 2000). The outcome measures included children who had one or more visits to an emergency department for asthma and who had one or more inpatient hospitalizations for asthma. Some of the findings are reflected below; however, please refer to Attachment C.I.d. for a copy of the full report.

Asthma Prevalence in the Study Population (those who meet continuous enrollment criteria):

Program	Numerator	Denominator	Treated Prevalence Rate
FFS	613	10,303	5.9%
MEDALLION	3,343	41,017	8.2%
Medallion II	3,690	51,534	7.2%
Total	7,646	102,854	7.4%

Demographic Characteristics of the Study Population by Program:

		Fee-for-Service	Medallion II	MEDALLION
Race	White	43.2%	15.0%	55.6%
	African-American	53.5%	83.3%	35.4%
	Other	3.3%	1.7%	9.0%
Gender	Male	56.9%	57.2%	59.0%
	Female	43.1%	42.8%	41.0%
Age	2-5 years	21.5%	32.0%	34.6%
	6-11 years	37.0%	40.3%	38.4%
	12-20 years	41.4%	27.7%	27.1%

It was noted that there were more African-American children in the Medallion II program which is likely due to the fact that during the study period, the Medallion II program was predominantly located in urban areas of the state: the Tidewater and Central Virginia regions. It has been documented in numerous studies that children who belong to minority groups have a higher incidence of asthma than do children from majority groups. Also of note is that children in the Fee-for-Service (FFS) program tended to be older than children in the other programs.

After controlling for race, no statistically significant differences between the three Medicaid programs were found. In addition, after controlling for both age and race, again, no statistically significant differences between the three Medicaid programs were found.

Based upon the demographic composition of enrollees, it would be reasonable to expect poorer results for the Medallion II program. The results suggest, however, that the Medallion II program performed on par with the FFS and MEDALLION programs when differences in the demographic composition of the programs are taken into account. These results echo those from other studies that found that clinical practice guidelines are used more frequently among pediatricians practicing in MCO settings.

<u>Adequacy of Prenatal Care</u> - The EQRO evaluated birth outcomes and prenatal care provided to Medicaid recipients. Measures included the percentage of women who received care in the first trimester of pregnancy and the adequacy of prenatal care. Birth outcomes were reported including the distribution of low and normal birth weight, macrosomia, fetal loss, congenital defects, and infant death. Data were obtained from the State's enrollment, claims, and

encounter files and from Virginia Department of Health birth certificate data. Results are reported for all eligible Medicaid recipients including those in the FFS, MEDALLION, and Medallion II programs. See Attachment C.I.d. for the clinical study, "Adequacy of Prenatal Care" performed by Delmarva Foundation, Inc. for State Fiscal Year 2000.

e.___ [MCOs only] Intermediate sanctions were imposed during the previous waiver period. Please describe.

Upcoming Waiver Period -- Please check any of the items below that the State requires. For items a through i, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Note: Elements a - g are requirements for States. Elements c, d and e are required for States which contract with MCOs and element d is required for States which contract with PHPs. The State:

a. √ Includes in its contracts with MCOs/PHPs, the State-required internal QAP standards. Please submit a copy of the State's Quality Assurance and Performance Improvement (QAPI) standards and/or guidelines currently required of MCOs/PHPs in their contracts as an attachment to this section (Attachment C.I.a).

See Attachment C.I.a. for a copy of the State's Quality Assurance and Performance Improvement (QAP) standards. The strategy was reviewed by several stakeholders for input.

The State includes the following requirements in its contracts with MCOs regarding Quality Improvement (QI):

The MCO must comply with 42 C.F.R. § 434.34, as amended, which requires each managed care organization that contracts with State Medicaid agencies to have an internal quality improvement program (QIP). Such QIP must meet the accreditation standards of NCQA. The MCO must send a copy of its quality improvement program and prior year's outcomes including results of HEDIS and other performance measures, quality studies, and other activities documented in the QIP to the State annually.

The MCO's QIP must consist of systematic activities to monitor and evaluate the care delivered to enrollees according to predetermined, objective standards and to make improvements as needed. The QIP must include provisions to perform the Consumer Assessment of Health Plans Survey (CAHPS) and report the results within the timeframe set by the State. CAHPS should be completed at least one

time during the Medallion II waiver period. The QIP must illustrate a comprehensive, integrated approach that encompasses all aspects of the health care delivery system for Medicaid. The MCOs must ensure that their grievance system is tied to their quality improvement program.

The MCO must cooperate with the State's QIP to the extent described and must demonstrate to the State, upon request, its degree of compliance with the State's quality standards. Additionally, the MCO and its subcontractors and network providers must cooperate with the State or designated agent in conducting the quality review process including data collection and data reporting on an annual basis.

Quality Studies

MCOs are required to adhere to NCQA standards and select HEDIS data reports, e.g., immunizations. The MCOs must submit annually and upon request to the State results of their internal quality studies including providing timely access to Medicaid recipients' medical records in the State's requested format. The MCOs must cooperate with and ensure the cooperation of network providers and subcontractors with the external review organization contracted by the State to perform quality studies.

Coordination and Continuity of Care

The MCO must have systems in place to ensure coordinated patient care. The systems, policies, and procedures are to be consistent with the most recent NCQA standards.

Coordination of QI Activity with Other Management Activity

The MCO's QI findings, conclusions, recommendations, actions taken, and results of actions taken must be documented and reported to appropriate individuals within the MCO's management organization and through the established QI communication channels. QI activities must be coordinated with other performance monitoring activities including the monitoring of enrollees' complaints and must reflect the most current requirements of NCQA.

Utilization Management Program Description

The MCO must have a written utilization management (UM) program description which includes procedures to evaluate medical necessity, criteria used, information source, and the process used to review and approve the provision of medical services. The program must demonstrate that enrollees have equitable access to care across the network and that UM decisions are made in a fair,

impartial, and consistent manner that serves the best interest of the enrollees. The program must reflect the standards for utilization management from the most current NCQA Standards. The program must have mechanisms to detect under-utilization and/or over-utilization of care including, but not limited to, provider profiles.

If the MCO delegates (subcontracts) responsibilities for UM with a subcontractor, the contract must have a mechanism in place to ensure that the standards are met by the subcontractor. The MCO must ensure that preauthorization requirements do not apply to emergency care, family planning services, preventive services, and basic prenatal care.

<u>Credentialing/Recredentialing Policies and Procedures</u>
The MCO's QIP must contain the proper provisions to determine whether physicians and other health care professionals who are licensed by the Commonwealth and who are under contract with the MCO are qualified to perform their medical or clinical services. The MCO must have written policies and procedures for the credentialing process that matches the credentialing and recredentialing standards of the most recent guidelines from NCQA. The MCO must have in place a mechanism for reporting serious quality infractions, resulting in suspension or termination of a practitioner's license, to the appropriate authorities.

<u>Monitoring and Evaluation of Enrollee Complaints</u>
The MCO must have in place a mechanism to link its enrollee complaints, grievances, and appeals system to the QIP. The MCO must, at a minimum, track trends in complaints and grievances and incorporate this information into the QI process. The MCO's complaints and grievances system must be consistent with the most current NCQA standards and DMAS guidelines.

Each MCO is required to complete and submit annually to DMAS all of the following HEDIS performance studies:

1) **Childhood Immunization Status**
2) **Adolescent Immunization Status**
3) **Breast Cancer Screening**
4) **Prenatal and Postpartum Care**
5) **HEDIS/CAHPS 2.0H Survey**
6) **Well-Child Visits in First 15 Months of Life**
7) **Well-Child Visits in Third, Fourth, Fifth, and Sixth Years of Life**
8) **Adolescent Well-Care Visit**

Notification of Sentinel Events

The MCO must maintain a system for identifying and recording the death of an enrollee. The MCO must provide the State with reports of sentinel events monthly. At a minimum, the following information must be documented on each event:

i. **Enrollee name;**
ii. **Enrollee Medicaid Identification number;**
iii. **Enrollee's PCP's name;**
iv. **Cause of death and the providers involved;**
v. **Date of occurrence; and**
vi. **Source of sentinel event data.**

b. √ Monitors, on a continuous basis, MCOs/PHPs adherence to the State standards, through the following mechanisms (check all that apply):

1. √ Review and approve each MCOs/PHPs written QAP. Such review shall take place prior to the State's execution of the contract with the MCO/PHP.

2. √ Review each MCOs/PHPs written QAP on a periodic schedule after the execution of the contract. Please specific frequency: **annually**

3. √ On-site (MCO/PHP administrative offices or service delivery sites) monitoring of the implementation of the QAP to assure compliance with the State's Quality standards. Such monitoring will take place (specify frequency) **biannually** for each MCO/PHP or attach the scope of work from the EQRO contract as an attachment to this section.

See Attachment C.I.b.3.

4. √ Conducts monitoring activities using (check all that apply):

(a) √ State Medicaid agency personnel

(b) Other State government personnel (please specify):

(c) √ A non-State agency contractor (please specify):
Delmarva Foundation, Inc.

5. ** Other (please specify):

c. √ Will arrange for an annual, independent, external review of the quality outcomes and timeliness of, and access to items and services delivered

under each MCO contract with the State. Note: Until additional guidance on EQR is released, please refer to existing regulations, State Medicaid Manual guidance, and the Quality Reform Initiative guidance in this area.

1. Please specify the name of the entity: **Delmarva Foundation, Inc.**

2. The entity type is:
(a) √ A Peer Review Organization (PRO).
(b) __ A private accreditation organization approved by HCFA.
(c) __ A PRO-like entity approved by HCFA.

3. Please describe the scope of work for the External Quality Review Organization (EQRO):

The EQRO must perform an annual review of each of the managed care organizations (MCOs) under contract with the State. The review must address issues of quality, access, and timeliness of care. Quality improvement plans must adhere to NCQA criteria and must address both clinical and non-clinical areas that address the needs of Medicaid enrollees. The EQRO must produce a detailed technical report that describes the manner in which the data from all activities were aggregated, analyzed, and conclusions drawn as to the quality of care furnished by each MCO.

d. √ Has established a system of periodic medical audits of the quality of, and access to, health care for each MCO/PHP on at least an annual basis. These audits will identify and collect management data (including enrollment and termination of Medicaid enrollees and utilization of services) for use by medical audit personnel. Note: Until additional guidance on EQR is released, please refer to existing regulations, State Medicaid Manual guidance, and the Quality Reform Initiative guidance in this area. States may, at their option, institute EQR reviews for PHPs. These periodic medical audits will be conducted by:

1. The entity type is:
(a) √ State Medicaid agency personnel
(b) __ Other State government personnel (please describe):
(c) √ A non-State agency contractor to the State (please describe):
Delmarva Foundation, Inc.
(d) ** Other (please describe):

2. Please attach the scope of work for the periodic medical audits.

The EQRO must perform clinical focus studies annually or bi-

annually and calculate performance measures. The focus studies include immunization compliance for children and the adequacy of prenatal care and birth outcomes.

Immunization Compliance

The EQRO must determine and report the immunization status of Medicaid enrollees who attain the age of two (2) during the study year. Special emphasis will be placed on determining the percentage of children who are fully immunized by the age of two, in accordance with the American Academy of Pediatrics immunization schedule in effect during the period under study. The EQRO must use a similar methodology established in studies performed in previous years although modifications, approved in advance by the State, must be made in order to increase the validity and utility of the results. Immunization data must be obtained from the State's claims and encounter databases, the Virginia Department of Health (VDH), and provider records. Results must be reported for all eligible Medicaid recipients including those in the FFS, MEDALLION, and Medallion II programs.

Adequacy of Prenatal Care and Birth Outcomes

The EQRO must evaluate birth outcomes and prenatal care provided to Medicaid recipients. Measures must include the percentage of women who receive care in the first trimester of pregnancy and the adequacy of prenatal care. Birth outcomes must be reported including the distribution of low and normal birth weight, macrosomia, fetal loss, congenital defects, and infant death. Data must be obtained from the State's enrollment, claims, and encounter files and Virginia Department of Health birth certificate data. Results must be reported for all eligible Medicaid recipients including those in the FFS, MEDALLION, and Medallion II programs. The EQRO must use a similar methodology as that established in studies performed in previous years although modifications must be made in order to increase the validity and utility of the results.

e. √ Has established intermediate sanctions that it may impose if the State makes a determination that an EQRO violates one of the provisions below. (Note: does not apply to PHPs).

f. √ Has an information system that is sufficient to support initial and ongoing operation and review of the State's QAPI.

g. √ Has standards in the State QAPI, at least as stringent as those required in

federal regulation, for access to care, structure and operations, quality measurement and improvement and consumer satisfaction.

h.__ Plans to develop and implement the use of QISMC in its quality oversight of MCOs/PHPs? (QISMC is a HCFA initiative to strengthen MCOs/PHPs' efforts to protect and improve the health and satisfaction of Medicare and Medicaid enrollees. The QISMC standards and guidelines are key tools that can be used by HCFA and States in implementing the quality assurance provisions of the Balanced Budget Act (BBA) of 1997. This is strictly a voluntary initiative for States) Please explain which domains will the State be implementing (check all that apply).

1.__ Domain 1 - Quality Assessment and Performance Improvement (QAPI) Program: Date of Implementation _____

2.__ Domain 2 - Enrollee Rights: Date of Implementation _____

3.__ Domain 3 - Health Services Management : Date of Implementation _____

4.__ Domain 4 - Delegation: Date of Implementation _____

i. √ Other (please describe)**:**

The MCO must demonstrate its ability to retain accreditation by the National Committee for Quality Assurance (NCQA). If not accredited by the NCQA, the MCO must seek NCQA accreditation within six months after the start of the Medallion II contract or thirty (30) calendar days after becoming eligible to seek NCQA accreditation, whichever is later. Denial of NCQA accreditation status may be cause for the State to impose remedies or sanctions depending upon the reasons for denial by NCQA. The State will recognize and accept accreditation from an organization other than NCQA if the participating MCO had applied or received that accreditation by December 2000. After that date, any request to have the State consider accreditation by another agency other than NCQA will be denied. The State currently has one MCO that has attained and been approved for accreditation by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). This MCO must adhere to certain NCQA standards.

II. Coverage and Authorization of Services

Previous Waiver Period

a.____ During the last waiver period, coverage and authorization of services were

different than described in the waiver governing that period. The differences were:

b. √ [Required for all elements checked in the previous waiver submittal] Please provide results from the State's monitoring efforts for compliance in the area of coverage and authorization of services for the previous waiver period, including a summary of any issues/trends identified in the areas of authorization of services and under/over utilization [items C.II.a-e in 1999 initial preprint; relevant sections of the 1995 preprint]. Please include the results from those monitoring efforts for the previous waiver period.

The following identifies the areas and topics that were addressed in the monitoring efforts. The MCOs were required to meet the following objectives:

- **Demonstrate compliance with minimum regulatory service requirements.**
- **Provide for delivery of specific Medicaid covered services.**
- **Determine and administer certain types of services with limitations or exclusions.**
- **Provide coverage and procedures for emergency services.**
- **Administer and provide programs to ensure attention to preventive and diagnostic health services for pregnant women, newborns, and children.**
- **Assure that the needs of special population enrollees are met (e.g. CSHCN, HIV/AIDS).**
- **Administer special programs as required by the Medallion II contract (e.g. EPSDT).**
- **Assure that "medical necessity" is a key component in the provision of services.**
- **Develop and apply utilization management criteria and guidelines that meet or exceed National Committee for Quality Assurance (NCQA) standards.**
- **Conduct utilization management operations and activities in compliance with Medicaid contract requirements.**
- **Provide guidance and direction to Primary Care Providers to follow NCQA standards of performance and Medicaid contract requirements.**
- **Administer case management processes and activities consistently and equitably for Medicaid enrollees.**
- **Conduct various authorizations for care and continuance of care processes in the best interest of the Medicaid enrollee.**
- **Provide medical oversight and review of all medical and utilization management processes and activities.**

Under NCQA standards and the Medallion II contract, a review by the

State of the utilization management program has occurred annually. The monitoring team found documentation that occurred in all participating MCOs. The following identifies some key findings:

Service Requirements

The MCOs exceeded the Commonwealth's Bureau of Insurance requirements to provide the following: adequate availability and access to care; a minimum of 90 days of inpatient and 30 days of outpatient care per contract period; out-of-area emergency services; 24 hour emergency telephone contact service; and supplemental health care services.

Covered Medical Services

All MCOs provided covered, mandated, and optional Medicaid services identified in the State Plan including inpatient services, outpatient services, clinical services, dental, EPSDT, emergency services, family planning, mental health, laboratory and x-ray, durable medical equipment, organ transplants, physical and occupational therapy, speech and audiology services, prescription drugs, prosthetics, and vision services. The MCOs also developed relationships with community safety net providers that rendered specialized treatment, care, and services such as the local departments of health, nutrition programs, and social services agencies. MCOs identified, defined, and specified the amount, duration, and scope of each service offered in recipient handbooks and evidence of coverage documents. The State provided guidance to the MCOs regarding coverage and authorization of atypical anti-psychotic medications, reinforcing the requirement that these medications must be made available to recipients as a "first line" drug in compliance with federal guidance communications.
All MCOs had policies and procedures to assure prompt, written, and verbal notification of the enrollee and provider when an adverse decision was made. Notices included the criteria used in the decision and information on how to appeal the decision.

Emergency Services

All of the MCOs implemented the required federal prudent layperson requirements for the provision of emergency services. All of the MCOs covered emergency services 7 days a week, 24 hours a day, whether in- or out-of-network without any prior approval, authorizations, or restrictions.

Preventive Health Services

Each MCO had written guidelines for the prevention and detection of illness and disease. The MCOs involved network physicians in the

development and adoption of preventive health guidelines. Throughout the year, the MCOs distributed guidelines to inform and encourage members to implement sound, preventive health and nutritional measures that improve their health status. Particular MCO preventive initiatives related to child immunizations, asthma, coronary artery disease screening, prenatal care, smoking cessation, breast cancer screening, and adult immunizations.

Medical Necessity

The State defined "medical necessity" in the Medallion II contract as services sufficient in amount, duration, and scope to reasonably achieve their purpose as defined in 42 C.F.R. § 440.230. The State further provided for the MCOs' "medically necessary services" in the Medallion II contract in addition to a summary of covered benefits. Each MCO adopted a definition of medical necessity that was defined in their member handbook or in their evidence of coverage.

The State monitored complaints and appeals submitted by Medallion II recipients. Complaint reports were received monthly from each MCO, the enrollment broker, and the State's Helpline. No trends were revealed during monitoring activities. During Fiscal Year 2002 (July 1, 2001 through June 30, 2002), complaints related to utilization and medical management made up less than two percent (<2%) of all complaints, and for the first seven months of SFY 2002, complaints related to utilization and medical management made up less than one percent (<1%) of all complaints. Instances where MCOs were suspected to be out of compliance with the State's definition of "medically necessary services" or the covered benefit schedule were resolved on a case-by-case basis through written and verbal communications with the MCOs.

All MCOs made allowances for the variety of formats and information necessary to make authorization decisions. Information may have included medical office and hospital records, benefit information, and information conveyed orally from providers and recipients. MCOs specified that documentation should reflect who rendered what service, why, when, and to whom. Plans provided documentation guidelines for medical/surgical records, inpatient and outpatient hospital records, ambulatory surgery records, and mental health records. All MCOs used criteria based on literature review, review of governmental regulations, and reference tools such as Milliman & Robertson, InterQual, Anesthesia Staging Criteria, Hayes Technology Assessment, FDA review, CMS decisions, and AMA guidelines. All MCOs had processes in place to ensure consistent application of review criteria and decisions. Processes included

organizational accountabilities and structures that review, monitor, manage, and facilitate operations of the UM departments.

Special Population Services

The MCOs developed a variety of systems and procedures to identify the needs of special populations such as children with special physical, mental, or developmental needs; individuals with physical disabilities; individuals with developmental disabilities; the homeless; and individuals with HIV/AIDS. The methods to identify these special populations included development of patient profiles, authorization requests, and personal interviews. The MCOs developed a network to serve those populations and implemented case management systems and staff to coordinate the care of special populations.

Enhanced Benefits and Services

The MCOs provided enhanced benefits and services beyond the Medicaid requirements for Medicaid recipients. These additional benefits were preventive health services for pregnant women, newborns, and children; adult dental services; adult vision services; and services to improve the health care status of adults with special health care needs.

Utilization Management

The State requires that all participating MCOs follow the NCQA standards for utilization and medical management. The NCQA standards require MCOs to structure their utilization management process, develop a plan, assign appropriate responsibilities and staffing, adopt criteria for determining medical appropriateness, require licensed physicians to review denials, establish timeframes for medical management decisions, document medical management decisions, document the process to provide new technologies and applications, and obtain member and provider feedback at least every two years.

The State requires that the MCO have a written utilization management (UM) program description that includes procedures to evaluate medical necessity, criteria used, information source, and the process used to review and approve the provision of medical services. The program has to demonstrate that enrollees have equitable access to care across the network and that UM decisions are made in a fair, impartial, and consistent manner that serve the best interest of the enrollees. The program has to have standards for utilization management from the most current NCQA standards. The program must have mechanisms to detect under-utilization

and/or over-utilization of care, including provider profiles.

MCO policies have to include that the attending physician is entitled to review the issue of medical necessity with the physician consultant or peer of the attending physician who represents the plan. MCOs assembled comprehensive lists of Board Certified specialists for the review of medical necessity or appropriateness. Advisors were also used to review concurrent hospital stays and determine appropriate levels of care.

If the MCO delegates responsibilities for UM to a subcontractor, the contract has to have a mechanism in place to ensure that the standards are met by the subcontractor. The MCO has to ensure that the preauthorization requirements do not apply to emergency care, family planning services, preventive services, and basic prenatal care. The UM plan has to be submitted annually or upon revision.

State staff review the MCOs' UM policies and procedures on an annual basis. Three of the four MCOs under contract during the majority of the waiver period were accredited by NCQA and met the State's requirements. The Joint Commission on Accreditation of Health Care Organizations (JCAHO) accredited one plan. The JCAHO criteria did not completely compare to the NCQA criteria; however, the Medallion II contract required the MCO to meet the criteria of NCQA where deficient. The external quality review organization (EQRO) under contract to the State evaluated the JCAHO-accredited MCO for compliance with the State's standards.

All MCOs implemented mechanisms to detect under and over-utilization of services. Plans used a variety of methods including HEDIS measures, ACG/Cochran Statistic Analysis, analysis of physician and enrollee complaints, physician report cards, Peer-A-Med, and utilization reports. MCOs typically monitored utilization of inpatient acute days, inpatient acute discharges, ambulatory visits by age group, emergency department visits, and the use of procedures such as myringotomy, tonsillectomy, and hysterectomy. MCOs used PCP analyses to detect under and over-utilization for high use/high cost diagnoses and procedures such as obstetrics and gynecology, general surgery, and ENT. Interventions were developed and implemented to address outliers. MCOs developed and implemented action plans for PCPs and specialists who were repeat outliers on measures of under and over-utilization.

All MCOs submitted documentation of their measures to evaluate under and over-utilization for standard areas such as inpatient days,

inpatient discharges, pharmacy utilization, and high-cost, high volume diagnoses and procedures. MCOs analyzed PCP utilization for under and over-utilization and provided feedback to providers. At the site visit, the EQRO also verified MCOs' quality improvement activities.

Primary Care Provider

The MCOs assisted the PCPs in fulfilling their responsibilities by having administrative policies and procedures in place that helped facilitate the provision of care. These administrative activities included providing an adequate network of specialty and ancillary providers, providing case management, creating and applying industry standard utilization management procedures, "user friendly" and timely authorization procedures, oversight of medical decisions by professional peers and the Medical Director, creation and dissemination of disease management protocols, and the provision of information regarding outcomes of the care provided.

The MCOs were required to describe the role of the PCP, provide PCP orientation training within 60 days, develop PCP referral, authorization, and follow-up procedures, assure that the PCP had knowledge of community resources and network providers, and develop provider profiles to assess over and under-utilization patterns. Providers who were identified as being "outliers" were to be counseled and monitored on an on-going basis to assure adherence to standards of practice.

Case Management

The MCOs have case managers for complex care situations, recipients with special health care needs, prenatal care, baby care, discharge planning, and concurrent review. The case managers worked closely with the State, communicating frequently and attending quarterly meetings. The MCOs developed written policies and procedures for case management and communicated these procedures to enrollees. The case managers provided patient management to ensure the delivery of coordinated care and medical management to assure the quality and cost effectiveness of care.

Authorization System

The MCOs used nationally recognized systems, standards, and criteria for determining the appropriate levels of care and lengths of stay for prior, concurrent, and retrospective reviews. The MCOs accepted prior authorizations made by the State or other Medicaid MCOs and have systems in place to authorize out-of-network or

extended benefits. All MCOs were able to link the authorization of medical services with the payment of claims, so unauthorized services were not paid. The MCOs met the authorization timeframes for decision-making, notification, and appeals required by NCQA and the Medallion II contract.

Medical Oversight
All MCOs have a plan and manage over and under-utilization patterns of care. The MCOs conducted specialized service and procedure utilization studies and assessed provider referral patterns. The results of all utilization monitoring were integrated with the MCO quality improvement efforts. A physician provided medical oversight of all medical and utilization management decisions of each MCO.

Disease Management
All MCOs established mechanisms for the adoption of treatment guidelines, involvement of practitioners in the development of those guidelines, and the communication of those guidelines to all providers (and enrollees when appropriate). MCO programs include pediatric asthma, diabetes, mental health, etc.

Upcoming Waiver Period -- Please check any of the processes and procedures from the following list that the State requires to ensure that contracting MCOs/PHPs meet coverage and authorization requirements. For items a through e, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Contracts with MCOs/PHPs:

a. √ Identify, define and specify the amount, duration and scope of each service offered, differentiating those services, which may be only available to special needs populations, as appropriate.

b. √ Specify what constitutes "medically necessary services" consistent with the State's Medicaid State Plan program (i.e., the FFS program). Please list that specification or definition:

"Medical necessity" is defined in the Medallion II contract as services sufficient in amount, duration, and scope to reasonably achieve their purpose as defined in 42 C.F.R. § 440.230. MCOs are responsible for covering services related to:

- **The prevention, diagnosis, and treatment of health impairments.**
- **The ability to achieve age-appropriate growth and**

development.

- **The ability to attain, maintain, or regain functional capacity.**

All medically necessary services are outlined in the Medallion II contract in addition to a summary of benefits.

c. √ Provide that the MCO/PHP furnishes the services in accordance with the specification or definition of "medically necessary services".

d. √ Ensure implementation of written policies and procedures reflecting current standards of medical practice and qualifications of reviewers for processing requests for initial authorization of services or requests for continuation of services. Policies include:

1. √ Specific time frames for responding to request

2. √ Requirements regarding necessary information for authorization decisions,

3. √ Provisions for consultation with the requesting provider when appropriate,

4. √ Providing for expedited response for urgently needed services

5. √ Clearly documented criteria for decisions on coverage and medical necessity that are based on reasonable medical evidence or a consensus of relevant medical professionals.

6. √ Criteria for decision on coverage and medical necessity are updated regularly.

7. √ Mechanisms to ensure consistent application of review criteria and compatible decisions.

8. √ A process for clinical peer reviews of decisions to deny authorization of services on the grounds of medical appropriateness.

9. √ Processes and procedures that ensure prompt written notification of the enrollee and provider when a decision is made to deny, limit, or discontinue authorization of services. (Note: current regulations require notice for a termination, reduction, or suspension of services which have already been authorized or when a claim for services is not acted upon with reasonable promptness. This check box should be marked when the State also requires notice when an enrollee's request for future services is denied, limited, or

discontinued.) Notices include (check all that apply):

(a)√ Criteria used in denying or limiting authorization

(b)√ Information on how to request reconsideration of the decision.

(c)__ Other (please describe):

10. √ Mechanisms that allow providers to advocate on behalf of enrollees within the utilization management process.

11. √ Mechanisms to detect both under utilization and over utilization of services.

12.__ Other (please describe):

e.___ Other (please describe):

III. Selection and Retention of Providers

Previous Waiver Period

a.___ During the last waiver period, the selection and retention of providers were different than described in the waiver governing that period. The differences were:

b. √ [Required for all elements checked in the previous waiver submittal] Please provide a description of how often and through what means the State monitored the process for selection and retention of providers checked in the previous waiver submittal [items C.III.a-h in the 1999 initial preprint; relevant sections of the 1995 preprint]. Also please provide results from the State's monitoring efforts for compliance in the area of selection and retention of providers for the previous waiver period.

As part of the network and provider relations function, the MCOs have developed and retained a comprehensive and integrated network of providers to ensure access, availability, adequacy, continuity, and appropriate levels of care and services for Medicaid recipients. The MCOs were required to meet the following objectives:

- **Develop and retain a comprehensive network of qualified providers.**
- **Comply with Medicaid specific contract requirements.**

- **Meet or exceed provider availability and access standards as defined in the Medallion II contract.**
- **Maintain a provider relations program.**
- **Develop and administer contracts with providers that meet or exceed all regulatory, reporting, and quality standards.**
- **Comply with Medicaid contract reimbursement requirements for special services and programs.**
- **Implement an on-going monitoring program of its provider network.**

The monitoring review indicated that the MCOs consistently have met the objectives noted above. Specifically, the MCOs met the contract requirements for network composition, availability, access standards, provider reimbursement, and provider monitoring.

The following reflects some of the key findings as a result of the monitoring effort:

<u>Credentialing</u>
All MCOs were required to implement initial credentialing and recredentialing processes that meet NCQA standards. The NCQA-accredited MCOs met these criteria. The JCAHO-approved MCO received a low score for credentialing and required a corrective action plan. As a result of the corrective action, JCAHO conferred the score of *Substantial Compliance* in this area.

All MCOs had a process of initial credentialing that included verification of primary source information, obtaining peer input, analysis of performance appraisal data, verification of sanctions, and office site visits. MCOs credential providers prior to allowing them to participate in their network, and recredentialing is performed every two years. MCOs use information from quality assessments, performance improvement activities, and a variety of tools for recredentialing purposes. Information included results of recipient satisfaction surveys, results from monitoring of medical records standards, including the quality and safety of care, documentation, and continuity and coordination of care, office site standards compliance, provider report cards, HEDIS data, and results of analyses of under and over-utilization.

<u>Network Composition</u>
The contracted MCOs delivered Medicaid services in 103 out of 134 cities and counties throughout the Commonwealth. On December 1, 2001, Medallion II expanded into Northern Virginia, Southwestern

Virginia, Danville, and Charlottesville. Each MCO was monitored by city and county to ensure that the type and specialty of providers were diverse and varied to deliver medically necessary services to meet the needs of the recipient. During calendar year 2001, there were few complaints identified by the MCOs, the State Helpline, or the enrollment broker that indicate the absence of a physician for a particular specialty. The MCOs worked with recipients and offered out of network referrals, as appropriate, and extended contracting and credentialing services to the providers.

Contract Requirements

The Medallion II contract requires the MCOs to meet standards with respect to the number of PCPs and general dentists available for a certain number of enrollees. This was also monitored, and the contracted MCOs met their requirements. In addition, the contract requires an MCO to ensure that recipients' medically necessary needs are met regardless of network composition at the time of enrollee need. All agreements or contracts signed by the MCO and PCPs contain a provision that ensures recipients 24 hours per day, 365 days per year, access to PCPs or their medical professional designee. This was monitored in the complaint documentation.

Provider Relations

Each of the contracted MCOs had a provider directory and a provider newsletter to communicate administrative requirements and changes to administration. MCOs have dedicated staff for recruitment and retention services.

Provider Reimbursement

The MCOs arranged their own provider reimbursement schedules. There were no co-payments, deductibles, or co-insurance levied in the Medallion II program. All provider contracts contained a "hold harmless" clause for recipients. Emergency room "triage" reimbursement was mandatory. There were complaints documented by the MCOs, State, and the enrollment broker related to provider reimbursement, but they were minimal and were usually related to the timeliness of payment rather than the denial of payment. All PCPs are reimbursed more than the Medicaid rate. All of the MCOs developed and organized their networks to meet the recipients' access, health, and transportation needs.

Upcoming Waiver Period

Please check any processes or procedures listed below that the State uses to ensure that each MCO/PHP implements a documented selection and retention

process for its providers. For items a through h, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. The State requires MCOs/PHPs to (please check all that apply):

a. √ Develop and implement a documented process for selection and retention of providers.

b. √ Have an initial credentialing process for physicians and other licensed health care professionals including members of physician groups that is based on a written application and site visits as appropriate, as well as primary source verification of licensure, disciplinary status, and eligibility for payment under Medicaid.

c. √ Have a recredentialing process for physicians and other licensed health care professionals including members of physician groups that is accomplished within the time frames set by the State, and through a process that updates information obtained through the following (check all that apply):

1. √ Initial credentialing

2. √ Performance indicators, including those obtained through the following (check all that apply):

(a) √ The quality assessment and performance improvement program

(b) √ The utilization management system

(c) √ The grievance system

(d) √ Enrollee satisfaction surveys

(e) Other MCO/PHP activities as specified by the State.

d. √ Use formal selection and retention criteria that do not discriminate against particular practitioners, such as those who serve high risk populations, or specialize in conditions that require costly treatment.

e. √ Determine, and redetermine at specified intervals, appropriate licensing/ accreditation for each institutional provider or supplier. Please describe any licensing/accreditation intervals required by the State

The State requires that MCOs follow the accreditation guidelines

from NCQA. Providers are recredentialed every two years, and facilities are recredentialed every three years.

f. √ Have an initial and recredentialing process for providers other than individual practitioners (e.g., home health agencies) to ensure that they are and remain in compliance with any Federal or State requirements (e.g., licensure).

g. √** Notify licensing and/or disciplinary bodies or other appropriate authorities when suspensions or terminations of providers take place because of quality deficiencies.

h. ___ Other (please describe):

IV. Delegation

Previous Waiver Period

a. ___ During the last waiver period, delegation was different than described in the waiver governing that period. The differences were:

b. √ [Required for all elements checked in the previous waiver submittal] Please provide results from the State's monitoring efforts for compliance in the area of delegation for the previous waiver period [items C.IV.a-i in 1999 initial preprint; relevant sections of the 1995 preprint].

MCOs used subcontractors to administer or arrange for certain types of services. All of the contracted MCOs used a pharmacy contractor. Some of the MCOs subcontracted for transportation, mental health, dental, and vision services. Some MCOs used subcontractors to perform credentialing and certain utilization management processes. Each of the MCOs accepted responsibility for the subcontractor's performance for compatibility with the Medicaid risk contract.

Upcoming Waiver Period

Please check any of the processes and procedures from the following list that the State uses to ensure that contracting MCOs/PHPs oversee and are accountable for any delegated functions in Section C. Quality of Care and Services. For items a through i, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Where any functions are delegated by MCOs/PHPs, the State Medicaid Agency:

a. √ Reviews and approves (check all that apply):

1. ___ All subcontracts with individual providers or groups

2. √ All model subcontracts and addendums

3. ___ All subcontracted reimbursement rates

4. √ Other (please describe):

Changes in the method of payment to provider subcontractors (e.g., fee-for-service to capitation) must be approved by the State.

b. √** Requires agreements to be in writing and to specify any delegated responsibilities.

c. √ Requires agreements to specify reporting requirements.

d. √ Requires written agreements to provide for revocation of the delegation or other remedies for inadequate performance.

e. ___ Monitors to ensure that MCOs/PHPs have evaluated the entity's ability to perform the delegated activities prior to delegation.

f. √ Ensures that MCOs/PHPs monitor the performance of the entity on an ongoing basis.

g. √ Monitors to ensure that MCOs/PHPs formally review the entity's performance at least annually.

h. √ Ensures that MCOs/PHPs retain the right to approve, suspend or terminate any provider when they delegate selection of providers to another entity.

i. ___ Other (please explain):

V. Practice Guidelines

Previous Waiver Period

a. ___ During the last waiver period, practice guidelines were different than described in the waiver governing that period. The differences were:

b. √ [Required for all elements checked in the previous waiver submittal] Please provide results from the State's monitoring efforts to determine the level of compliance in the area of practice guidelines for the previous waiver period [items C.V.a-h in 1999 initial preprint; relevant sections of the 1995 preprint].

All of the MCOs have practice guidelines that are reviewed by DMAS.

- **(Section C.V.a.) The clinical practice guidelines were based on reasonable medical evidence.**

- **(Section C.V.a.) These preventive health guidelines or their predecessors had been available for use for at least two years.**

- **(Sections C.V.a. and C.V.b.) Each guideline described the prevention or early detection interventions and the recommended frequency and conditions under which the interventions were required. The MCOs documented the scientific basis or authority on which they based the preventive health guidelines.**

- **(Section C.V.b.) The MCOs had preventive health guidelines for the prevention or early detection of illness and disease.**

- **(Section C.V.b.) The MCOs had guidelines for the following categories**
    - **Prenatal and perinatal care**
    - **Preventive care for infants up to 24 months**
    - **Preventive care for children and adolescents, 2–19 years**
    - **Preventive care for adults, 20–64 years**
    - **Preventive care for the elderly, 65 years and older**

- **(Section C.V.c.) Practitioners from the MCOs who had appropriate knowledge had been involved in the adoption of the preventive health guidelines.**

- **(Section C.V.c.) The MCOs involved their practitioners in the adoption of clinical practice guidelines.**

- **(Section C.V.d.) The MCOs had developed a mechanism for reviewing the guidelines at least every two years and updating them, as appropriate.**

- **(Section C.V.d.) For those preventive health guidelines that had been in place for at least two years, there was evidence of review and update at least once every two years, where appropriate.**

- **(Section C.V.e.) The MCOs were accountable for adopting and disseminating practice guidelines for the provision of acute, chronic and behavioral health services that were relevant to its enrolled membership.**

- **(Section C.V.e.) The MCOs distributed the guidelines to their**

practitioners.

- **(Seciton C.V.f) Annually, the MCOs measured performance against at least three guidelines, one of which related to behavioral health.**

- **(Section C.V.f.) Decision making in utilization management, member education, interpretation of covered benefits, and other areas to which the clinical guidelines were applicable was consistent with the guidelines.**

- **(Section C.V.g.) The MCOs implemented a process to assess new technologies and new applications of existing technologies.**

JCAHO standards addressed practice guidelines in the evaluation area *of Performance Improvement Process* (PIP). The PIP was required to be collaborative, involve clinical staff, and incorporate information from scientific and professional sources such as practice guidelines and clinical standards. In addition, there was a formal process for developing and revising policies and procedures, and leaders had to establish and maintain effective internal and external communication. In addition, the MCO was required to continuously measure important processes. Monitoring of the JCAHO accredited MCO Quality Improvement Plan found that the MCO complied with State standards for practice guidelines.

Upcoming Waiver Period - Please check any of the processes and procedures from the following list that the State requires to ensure that contracting MCOs/PHPs adopt and disseminate practice guidelines (please check all that apply). For items a through h, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Guidelines:

a. √ Are based on reasonable medical evidence or a consensus of health care professionals in the particular field.

b. √ Consider the needs of the MCOs/PHPs enrollees.

c. √ Are developed in consultation with contracting health professionals.

d. √ Are reviewed and updated periodically.

e. √ Are disseminated to all providers, all enrollees (as appropriate) and individual enrollees upon request.

f. √ Are applied in decisions with respect to utilization management, enrollee education, coverage of services, and other relevant areas.

g. √ Develop and implement policies and procedures for evaluating new medical technologies and new uses of existing technologies.

h. ___ Other (please explain):

VI. Health Information Systems

Previous Waiver Period

a. ___ During the last waiver period, health information systems of contracting MCOs/PHPs were different than described in the waiver governing that period. The differences were:

b. √ [Required for all elements checked in the previous waiver submittal] Please provide results from the State's monitoring efforts for compliance in the area of health information systems for the previous waiver period [items C.VI.a-i in 1999 initial preprint; relevant sections of the 1995 preprint].

For those areas of the previous waiver which were checked, below are the results of the State's monitoring efforts to ensure that the MCOs maintained a health information system that collected, analyzed, integrated, and reported data and achieved the objectives of Medallion II.

The Management Information System (MIS) functions are the backbone of the MCO's Medicaid Risk Program. They support all functions of the business and provide information with which the MCOs make decisions about how to best manage their business. The MCOs were required to meet industry standards, be efficient, operate in an integrated environment, and have dynamic and diversified information systems in order to continue doing business with the State. The Medallion II contract required the MCOs to meet three system objectives:

- **Establish an MIS system that provides the capacity to collect, analyze, and exchange data necessary to manage their business and the Medicaid program.**
- **Provide encounter data to the State that is accurate, complete, and timely.**
- **Provide periodic reports, documents, and notices that enable the State to monitor MCO enrollment processing, claims processing, provider network adequacy, and member inquiries and complaints.**

All MCOs met State requirements for MIS functions with respect to system capacity, encounters, and reporting requirements. A review of the MCO systems capacity indicated that each MCO has sufficient capabilities to meet the contractual requirements of the State. MCOs had scaleable, industry-standard hardware and software with adequate capacity to handle current and future Medicaid demands. The hardware and software for each plan is identified below:

- **Sentara Family Care: Hewlett Packard 9000 V supporting CSC Healthcare MHC System.**
- **Southern Health Services: DEC platform running IDX Managed Care Applications.**
- **Trigon HealthKeepers: Hewlett Packard using Amisys.**
- **UNICARE Health Plan: UNIX environment running Diamond 950.**
- **Virginia Premier: DEC platform running IDX Managed Care Applications.**

(Section C.VI.a.) The State requires MCOs to maintain a record keeping and tracking system for complaints, grievances, and appeals that include a copy of the original written grievance, the decision, and the nature of the decision. MCOs submitted monthly complaint reports to the State, and the State tracked the number of complaints by complaint category. The external quality review organization reviewed MCO grievance and complaint logs at their site visit in order to determine compliance with the State standards with respect to timeframes and to verify that information from complaints and grievances were integrated into the MCOs' quality improvement plans. Information on utilization was provided via encounter data. In addition, MCOs are required to submit inpatient hospital cost reports on a monthly basis. All plans complied with these requirements.

(Section C.VI.b.) MCOs are required to collect data on provider characteristics related to specialty type and languages spoken other than English. All MCOs complied with State requirements.

(Section C.VI.c.1.) All MCOs recorded data sufficient to identify the provider of services to enrollees.

(Section C.VI.c.2.) All MCOs were able to verify whether services reimbursed by Medicaid were actually furnished to enrollees by providers and subcontractors.

(Section C.VI.c.3.) All MCOs were capable of verifying the accuracy and timeliness of data.

(Section C.VI.c.4.) All MCOs had systems that were capable of screening data for completeness, logic, and consistency.

(Section C.VI.c.5.) All MCOs had systems that were capable of collecting service information in standardized formats in order to meet State standards.

(Section C.VI.d.1.) MCOs reported HEDIS results annually, encounter data monthly, and EPSDT information to complete the HCFA 416 reporting requirements.

(Section C.VI.d.2.) MCOs reported HEDIS results annually and results of performance measurements as identified in each MCO's annual Quality Improvement Plan or by the State.

(Section C.VI.d.3.) All MCOs submitted encounter data on a monthly basis.

(Section C.VI.d.4.) MCOs reported deaths to the State and submitted information on complaints, grievances, and appeals filed by enrollees in a timely manner. All MCOs reported the percent of two-year-old children who were fully immunized as part of their HEDIS measures or through special studies. Monthly hospital inpatient days reports were submitted by all MCOs as well as quarterly live birth reports, baby care enrollment reports, and monthly operational reports, as required by the State.

(Section C.VI.e.) All MCOs maintained systems sufficient to support the implementation of their QAP.

(Section C.VI.f.) MCOs are required to ensure that all providers receive proper education and training regarding the Medallion II managed care program to comply with this contract and all applicable Federal and State requirements. MCOs offered educational and training programs that covered topics or issues, including billing instructions which are in compliance with the State's encounter data submission requirements.

(Section C.VI.g.) The State monitored the MCOs through various reporting methodologies that were required through the Medallion II contract. These reports were received monthly, quarterly, and

annually.

(Section C.VI.h.) The Medallion II contract states that the MCOs must require all network providers to maintain medical records in paper or electronic format for all enrolled enrollees. The MCOs maintained standards for medical records that reflect the medical records standards of NCQA. MCOs reviewed physician medical records during site visits performed during the credentialing process and reviewed a random sample of medical records throughout the year.

c. √ Please provide a description of the current status of the State's encounter data system, including timeliness of reporting, accuracy, completeness and usability of data provided to the State by MCOs/PHPs.

Each MCO has submitted an encounter submission schedule to the current fiscal intermediary, First Health. Each MCO is monitored for timeliness of encounter submissions based on this schedule. Rarely, submission schedules lapse, but the MCOs are very responsive and quickly submit backlogged submissions and restore the schedule. Encounter submissions are monitored for accuracy and completeness.

Submitted encounter data have had very few serious errors due to the stringent testing process at implementation. The majority of errors typically involve Medicaid provider and recipient numbers. All error and warning messages are retained in a database for tracking and follow-up. Transmissions with greater than five percent fatal errors or ten percent duplicate services are failed and returned to the MCO plan. The files are corrected and resubmitted after the problem has been identified and resolved.

The State used encounter data in the Pediatric Asthma clinical focus study and uses encounter data for the HCFA 416 report. DMAS' Division of Policy and Research also uses encounter data for ad hoc analyses. Encounter data are used by DMAS staff for evaluating patterns of care, not rate setting. Data used for rate setting are sent directly to DMAS' actuaries. PriceWaterhouseCoopers has evaluated encounter data including all visits. Discrepancies led to their not using encounter data for rates.

Further evaluation of the encounter data has been delayed, due to the fact that the State Fiscal Agent's time is dedicated to the completion of the new Medicaid Management Information System and preparation for HIPPA implementation. The State is in the process of evaluating the direction in which to take the encounter

data system and hopes to improve its system within the next waiver period. Encounter data may be suspended for several months until the implementation of Virginia's MMIS in late 2003.

d. √** The State uses information collected from MCOs/PHPs as a tool to monitor and evaluate MCOs/PHPs (i.e. report cards). Please describe.

Clinical studies, ad hoc reports, dental utilization, prevalence data

e. √ The State uses information collected from MCOs/PHPs as a tool to educate beneficiaries on their options (i.e. comparison charts to be used by beneficiaries in the selection of MCOs/PHPs and/or providers). Please describe.

The State contracts with an enrollment broker who creates comparison charts, by region, based upon the facilities included in each MCO network. In addition, the comparison charts enumerate the enhanced benefits or services offered by each MCO.

Upcoming Waiver Period

Please check any of the processes and procedures from the following list that the State requires to ensure that contracting MCOs/PHPs maintain a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of the Medicaid Program. For items a through i, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. The State requires that MCOs/PHPs systems:

a. √ Provide information on
1. √ Utilization,
2. √ Grievances,
3. ___ Disenrollment. **(Disenrollment is handled by the State, not the MCOs.)**

b. √ Collect data on enrollee and provider characteristics as specified by the State.

c. √ Collect data on services furnished to enrollees through an encounter data system or such other methods approved by the State (please describe).

All MCOs submit encounter data of all claim submissions. All error and warning messages are retained on a database for tracking and follow-up. Transmissions with greater than five percent fatal errors or ten percent duplicate services are returned to the MCO plans. The files are to be corrected and resubmitted after the problem has been identified and resolved.

The MCO/PHP is capable of (please check all that apply):

1. √ [Required] Recording sufficient patient data to identify the provider who delivered services to Medicaid enrollees

2. √ [Required] Verifying whether services reimbursed by Medicaid were actually furnished to enrollees by providers and subMCOs

3. √ Verifying the accuracy and timeliness of data

4. √ Screening data for completeness, logic and consistency

5. √ Collecting service information in standardized formats to the extent feasible and appropriate

6. ___ Other (please describe):

d. √ Provide periodic numeric data and/or narrative reports describing clinical and related information for the Medicaid enrolled population in the following areas (check all that apply):

1. √ Health services (please specify frequency and provide a description of the data and/or content of the reports)

   HEDIS reports annually, encounter data, and EPSDT information to complete the HCFA 416 reporting requirements.

2. √ Outcomes of health care (please specify frequency and provide a description of the data and/or content of the reports)

   Annual HEDIS reports and results of outcome and performance measures as identified in each MCO's annual Quality Improvement Plan.

3. √ Encounter Data (please specify frequency and provide a description of the data and/or content of the reports)

   Encounters are defined as any service received by the enrollee and paid for by the contractor and are reported to DMAS monthly. This includes, but is not limited to, inpatient and outpatient procedures, EPSDT screens, transportation, pharmacy, durable medical equipment, and home healthcare services. The MCO is also responsible for submission of data from all of its subcontractors to the State or its agent.

4. √ Other (please describe and please specify frequency and provide a description of the data and/or content of the reports)

MCOs must report to the State:

Annually:

- **Report of the percent of two-year-old children who have received each immunization specified in the most current Advisory Committee on Immunization Practices (ACIP) recommendations.**
- **Quality Improvement Plans**
- **Results of Quality Improvement Plans**

Quarterly

- **Live birth outcomes report**
- **Baby-care enrollment reports.**
- **Provider network reports.**

Monthly

- **Logs of complaints, grievances and appeals filed by enrollees and providers.**
- **Hospital inpatient days report for adults, pediatrics, and nursery including premature infant and sick baby days, neonatal intensive care, psychiatric, rehabilitation, and denied days.**
- **Operations information reports on claims performance, inpatient authorizations, and status of PCP panels.**
- **Live Birth Report**
- **Sentinel Events - MCOs must report all enrollee deaths to the State monthly and within ten days of the event.**

e. √ Maintain health information systems sufficient to support initial and ongoing operation, and that collect, integrate, analyze and report data necessary to implement its QAP.

f. √ Ensure that information and data received from providers are accurate, timely and complete.

g. √ Allow the State agency to monitor the performance of MCOs/PHPs using systematic, ongoing collection and analysis of valid and reliable data.

h. √ Ensure that each provider furnishing services to enrollees maintains an enrollee health record in accordance with standards established by the organization that take into account professional standards.

i.___ Other (please describe):

VII. Quality Assessment and Performance Improvement (QAPI)

Previous Waiver Period

a.___ During the last waiver period, the State's Quality Assessment and Performance Improvement (QAPI) program was different than described in the waiver governing that period. The differences were:

b. √ [Required for all elements checked in the previous waiver submittal] Please provide results from the State's monitoring efforts to determine the level of compliance in the area of QAPI for the previous waiver period [items C.VII.a-u in 1999 initial preprint; relevant sections in the 1995 preprint]. Please break down monitoring results by subpopulations if available.

(Section C.VII.a.1.) All MCOs had policy-making bodies that oversaw the QAPI.

(Section C.VII.a.2.) All MCOs had a designated senior officer responsible for program administration and documentation of the Quality Improvement committee activities.

(Section C.VII.a.3.) All MCOs had policies and procedures aimed at including the active participation by providers and consumers.

(Section C.VII.a.4.) All MCOs' policy and procedures included a process for ongoing communication and collaboration among the Quality Improvement policy-making body and other functional areas of the organization. The QI Committee, which communicates regularly, met with the pharmacy committee, medical management bodies, utilization management staff, the Medical Director, the Board of Directors, and practitioner and provider committees.

(Section C.VII.c.) The State set two target performance levels which stated that eighty-five percent of two-year-old children were to be fully immunized, and the MCO would show continued improvement in the percentage of pregnant Medicaid recipients who receive prenatal care that meets accepted standards.

A goal of eighty-five percent completion rate for childhood immunizations was ambitious. Two MCOs met or exceeded this goal for the Measles Vaccine during the waiver period, and several MCOs achieved rates of over eighty percent for Polio. Two MCOs achieved

rates of over eighty percent for the Diphtheria/Tetanus/Pertusis series. All MCOs achieved improvements in immunization completion rates during the waiver period.

In general, MCOs showed improvements in prenatal care. The State defined adequacy of prenatal care as the percent of women who began care in the first trimester of pregnancy. The prenatal care study performed by George Mason University for service delivered during State Fiscal Years 1998 and 1999 showed the following:

Care in 1st Trimester	FFS	MEDALLION	Medallion II
1998	71.0%	77.1%	69.5%
1999	70.4%	76.8%	69.2%

Delmarva Foundation, Inc. performed a study for women who delivered during State Fiscal Year 2000. It must be noted that the majority of women in the MCOs who delivered babies became eligible for Medicaid because of their pregnancy. Therefore, Medicaid eligibility was established after conception, and due to the period of pre-assignment, it took one to three months after Medicaid eligibility determination for women to be enrolled in an MCO. Also, because reimbursement for prenatal care is bundled with delivery, and dates of prenatal care visits are not included in billing data, it was not possible to accurately account for the adequacy of prenatal care visits to a particular system of care. Please see Attachment C.I.d., "Adequacy of Prenatal Care Study".

c.___ The State or its MCOs/PHPs conducted performance improvement projects that achieve, through on-going measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical care and non-clinical services that can be expected to have a beneficial effect on health outcomes and enrollee satisfaction. Please list and submit findings from the projects completed in the previous two year period.

Upcoming Waiver Period- Please check any of the processes and procedures from the following list that the State requires to ensure that contracting MCOs/PHPs maintain an adequate QAPI. For items a through u, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. The State requires that MCOs/PHPs (check all that apply and note in narratives if the State intends to break down the results by subpopulation):

a. √ Have an adequate organizational structure which allows for clear and appropriate administration and evaluation of the QAPI. The State has

standards which include (check all that apply):

1. √ A policy making body which oversees the QAPI

2. √ A designated senior official responsible for program administration and documentation of Quality Improvement committee activities.

3. √ Active participation by providers and consumers

4. √ Ongoing communication and collaboration among the Quality Improvement policy making body and other functional areas of the organization.

5. ___ Other (please describe):

b. ___ Measure their performance, using standard measures established or adopted by the State Medicaid agency, and reports their performance to the applicable agency. Please list or attach the standard measures currently required.

c. √ Achieve required minimum performance levels, as established by the State Medicaid agency on standardized quality measures. Please list or attach the standardized quality measures established by the State Medicaid agency.

Completed immunizations by age two – 85%.

d. √ Conduct performance improvement projects that achieve, through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical care and non-clinical services that can be expected to have a beneficial effect on health outcomes and enrollee satisfaction.

Please list the projects currently planned for each year of the waiver period either at a state or plan-level. Please describe the types of issues that are included in clinical (e.g., acute/chronic conditions, high-volume/high-risk services) and non-clinical (e.g., complaints, appeals, cultural competence, accessibility) focus areas as defined by the State.

The State will participate in the Government Performance and Improvement Act Immunization Project. Currently, the State is in the process of developing interventions. The goal of the project is to increase the number of two-year-old children in Medicaid who have complete immunizations. The State defines immunization completion as completion of the 4:3:1 series (4 DTP; 3 Polio; 1 MMR). The immunization study completed by Delmarva Foundation, Inc. in

2002 (using 2000 data) will serve as the baseline measure, and Delmarva is contracted to conduct two follow-up studies over the next two years.

Each MCO is required to complete and submit annually to DMAS the following HEDIS performance studies:

1) **Childhood Immunization Status**
2) **Adolescent Immunization Status**
3) **Breast Cancer Screening**
4) **Prenatal and Postpartum Care**
5) **HEDIS/CAHPS 2.0H Survey**
6) **Well-Child Visits in First 15 Months of Life**
7) **Well-Child Visits in Third, Fourth, Fifth, and Sixth Years of Life**
8) **Adolescent Well-Care Visit**

The MCO contract requires MCOs to report quarterly birth outcome data. MCOs must submit reports electronically, and DMAS staff closely review birth outcome statistics.

MCO contracts require that each MCO quality improvement plan must consist of systematic activities to monitor and evaluate the care delivered to enrollees according to predetermined, objective standards and to make improvements as needed. Additionally, the QIP must include provisions to perform the Consumer Assessment of Health Plans Survey (CAHPS) at least once during the waiver period and report results to the State. The QIP must illustrate a comprehensive, integrated approach that encompasses all aspects of the health care delivery system for Medicaid. The State does not require specific project topics but does stress the importance of prenatal programs, childhood immunization, asthma treatment, dental access, and EPSDT.

The MCO contract requires MCOs to report quarterly birth outcome data. Beginning July 2002, MCOs must submit reports electronically, and DMAS will closely review birth outcome statistics within and between MCOs.

e. √ Correct significant systemic problems that come to its attention through internal surveillance, complaints, or other mechanisms.

f. √ Are allowed to collaborate with one another on projects, subject to the approval of the State Medicaid agency.

g. √ Are allowed to conduct multi-year projects that meet the improvement standards as described in QISMC or that are specified in a project work plan developed in consultation with the State Medicaid agency.

h. √ Select topics for projects through continuous data collection and analysis by the organization of comprehensive aspects of patient care and member services.

i. √ Select and prioritize topics for projects to achieve the greatest practical benefit for enrollees.

j. √ Select topics in a way that takes into account the prevalence of a condition among, or need for a specific service by, the organization's enrollees; enrollee demographic characteristics and health risks; and the interest of consumers in the aspect of care or services to be addressed.

k. √ Provide opportunities for enrollees to participate in the selection of project topics and the formulation of project goals.

l. √ Assess and measure the organization's performance for each selected topic using one or more quality indicators.

m. √ Base the assessment of the organization's performance on systematic, ongoing collection and analysis of valid and reliable data.

n. √ Establish a baseline measure of performance on each indicator, measure changes in performance, and continue measurement of at least one year after a desired level of performance is achieved.

o. √ Use a sampling methodology that ensures that results are accurate and reflective of the MCOs/PHPs enrolled Medicaid population.

p. √ Meet previously-determined standards to define results that show significant demonstrable improvement in performance as evidenced in repeat measurements of the quality indicators specified for each performance improvement project identified.

q. √ Use benchmarks levels of performance which are either determined in advance by the State Medicaid agency or by the organization.

r. √ Ensure that improvement is reasonably attributable to interventions undertaken by the organization (has face validity).

s. √ Administer their QAPI through clear and appropriate administrative arrangements.

t. √ Formally evaluate, at least annually, the effectiveness of the QAPI strategy, and make necessary changes.

u. ___ Other (please describe):

Section D. Cost Effectiveness

In order to demonstrate cost effectiveness, a waiver renewal request must demonstrate that it was cost-effective during the previous two-year waiver period (Years 1 and 2) and must show that the cost of the waiver program will not exceed what Medicaid costs would have been in the absence of the waiver in the upcoming two-year waiver period (Years 3 and 4).

With respect to waivers involving capitated reimbursement, a State's computation of its UPL (as required by 42 CFR 447.361) may serve the dual purpose of computing the projected Medicaid costs in the absence of the waiver as well. **The UPL is only one component of waiver cost effectiveness, which must also include comparisons of a State's administrative costs and relevant FFS costs with and without the waiver as well.**

CMS offers the following suggestions to States in completing this section:

- States are strongly encouraged to use the revised waiver preprint format to reduce the number of questions regarding their cost-effectiveness calculations. Please note that use of the revised preprint is optional.

- Cost effectiveness for 1915(b) waivers is measured in total computable dollars (Federal and State share).

- States are not be held accountable for caseload changes when submitting their waiver renewal cost-effectiveness calculations for services. States should have Per Member Per Month (PMPM) costs for the 2-year period equal to or less than projected Without Waiver costs as calculated in Step 18 of Appendix D.IV of their initial preprint. **Please ensure that you are using the PMPM Without Waiver costs that were approved in the previous waiver in your renewal.** In addition, States will also not be held accountable for benefit package, payment rate, or other programmatic changes made to the waiver program.

- Waiver expenditures should be reported on the Quarterly Medicaid Statement of Expenditures (Form HCFA-64 Report), according to reporting instructions in the State Medicaid Manual, Section 2500. If the State has specific questions regarding this requirement, please contact your State's CMS accountant in the Regional Office.

- A set of sample preprint Appendices has been included with this preprint using Year 2 of one State's experience (DSAMPLE.XLS). Blank Appendices have been included for your use (APPD.XLS). **Please modify the spreadsheets to meet your State's UPL and rate development techniques, using the State's capitated rate cells (most states use eligibility category, age, and gender-adjusted cells)**. If a waiver program does not cover all categories of service, the State should modify the spreadsheet to include only covered services. Please submit the electronic spreadsheets used to create the Appendices to CMS (CMS

currently uses Excel, which will convert both Lotus and QuatroPro). Please structure the worksheets as schedules which can link the totals between spreadsheets and roll up into a summary if the State has that capability. Linking the sheets and summaries will reduce copying from one schedule to another, which may introduce errors.

- The costs and enrollment numbers for voluntary populations (i.e., populations which can choose between joining managed care and staying in FFS) should be excluded from the waiver cost-effectiveness calculations if these individuals are not included in the waiver. In general, CMS believes that voluntary populations should not be included in 1915(b) waivers (i.e., excluded in Section A.II.l and A.II.m). If the State wants to include voluntary populations in the waiver (i.e., listed in Section A.III.b.3), then the costs and enrollment numbers for the population must be included in the cost-effectiveness calculations. In addition, States that elect to include voluntary populations in the waiver are required to submit a written explanation of how selection bias will be addressed in the rate setting or with waiver calculations. CMS may require the State to adjust its upper payment limits for the voluntary population to account for selection bias.

Description of the Cost-Effectiveness Calculation Process:
In general, the UPL for capitation contracts on a risk basis (e.g., MCO, HIO, or PHP) is the State agency's estimated cost of providing the scope of services covered by the capitation payment if these services were provided on a FFS basis. Documentation for the without waiver costs must be calculated on a per member per month basis.

- In order to determine cost-effectiveness, States must first document the number of member months participating in the waiver program for the previous waiver period (Year 1 and Year 2). They must then estimate the number of member months for the target population which will participate in the waiver program for the upcoming waiver period (Year 3 and Year 4) See Appendix D.II, Steps 1-4. The member months estimation should be based on the actual State eligibility data in the base year and the experience of the program in Year 1 and Year 2.

- The base year and the source of the without waiver data need to be identified for Years 1 - 4. The sources for this data and any adjustments to this data must be listed (Appendix D.III, Steps 5-9). If the State is proposing to use a different methodology for Years 3 and 4, please document all differences between the methodologies. Without Waiver Costs should be created using a FFS UPL based on FFS data with FFS utilization and FFS inflation assumptions. CMS recommends that a State use at least three years of FFS Medicaid historical data to develop utilization and inflation trend rates.

- Statistically valid (as defined by the State's actuary) without waiver cost and eligibility data for the population to be covered must be established. Base years should be specific to the eligibility group and locality covered by the contract and, to the extent possible, the costs included in the capitation rates. The exception

to this would be where the size of the group is not sufficiently large to represent a statistically valid sample. These base year costs need to be broken down into each of the main service categories covered under the contract--inpatient hospital, outpatient hospital, physician, lab and x-ray, pharmacy, and other costs (Appendix D.IV, Steps 10-13).

- Once the base year costs are established, States need to make adjustments to that data in order to update it to the year to be covered by the capitation contract. These adjustments represent the impact on Medicaid costs from such things as inflation, utilization factors, administrative expenses, program changes, reinsurance or stop-loss limits, and third party liability. When these adjustments are computed and factored into the base year costs, the end result is a projected UPL for the year under contract (Appendix D.IV, Steps 14-16). The State then needs to consider the effect of costs which are outside the capitation rate (and therefore outside the UPL), but are affected by the capitated contractor. These services are generally referred to as wraparound services, and may include such services as pharmacy. Because the capitated contractor can affect the costs of these wraparound services, they must be included in the without waiver cost development (Appendix D.IV, Steps 17-18). Without waiver costs must be developed for all Years 1 - 4.

- States must document actual PMPM costs under the waiver for the previous two-year period. They also must estimate the PMPM costs under the upcoming waiver period. The costs should include services controlled by the waiver but not in the capitated rate, plus the agency's average per capita administrative costs related to these services (Appendix D.V, Steps 19-29).

- States must then calculate the aggregate costs without the waiver and the aggregate costs with the waiver (Appendices D.VI, D.VII, Steps 30-35).

- States must clearly demonstrate that, when compared, payments to the contractor did not exceed the UPL in the past two years and will not exceed the UPL in the future two years (Appendix D.VIII, Steps 36-37), and costs under the waiver did not exceed costs without the waiver costs in the previous period and will not exceed without waiver costs in the future (Appendix D.VIII, Steps 38-40).

Assurance (Please initial or check)

___√___ The fiscal staff in the Medicaid agency has reviewed these calculations for accuracy and attests to their correctness.

Name of Medicaid Financial ~~Officer~~ **Contact: Stanley N. Fields, Director, Division of Cost Settlement and Reimbursement**

Telephone Number**: (804)786-5590**

The following questions are to be completed in conjunction with the Worksheet Appendices. We have incorporated step-by-step instructions directly into the worksheet using instruction boxes. Where further clarification was needed, we have included additional information in the preprint. All narrative explanations should be included in the preprint.

I. Type of Contract The response to this question should be the same as in **A.II.e**.

a. √ Risk-comprehensive (fully-capitated--MCOs, HIOs, or certain PHPs)
b. ___ Other risk (partially-capitated--PHP)
c. ___ Non-risk. Please use Section C of the PCCM initial application.
d. ___ Other (please explain):

II. Member Months: Appendix D.II.

Purpose: To provide data on actual and projected enrollment during the waiver period. Actual enrollment data for the previous waiver period must be obtained from the State's tracking system. Projected enrollment data for the upcoming period is needed to determine whether the waiver is likely to be cost effective. This data is also useful in assessing future enrollment changes in the waiver.

Step 1: Please list the rate cells which were used in setting capitation rates under the waiver. The number and distribution of rate cells will vary by State. If the State used different cells in Years 1 & 2 than in Years 3 & 4, please create separate tables for the two waiver periods. The base year should be the same as the FFS data used to create the PMPM without waiver costs. Base year eligibility adjustments such as shifts in eligibility resulting in an increase or decrease in the number of member months enrolled in the program should be noted here. Note: because of the timing of the waiver renewal submittal, the State may need to estimate up to six (6) months of enrollment data for Year 2 of the previous waiver period.

Step 2: See instruction box. If the State estimates that all eligible individuals will not be enrolled in managed care (i.e., a percentage of individuals will be unenrolled because of eligibility changes and the length of the enrollment process) please note the adjustment here.

Step 3: See instruction box. In the space provided below, please explain any variance in member months, by region, from Year 1 to Year 4.

Step 4: See instruction box. In the space provided below, please explain any variance in total member months from Year 1 to Year 4.

a. Population in base year data

1. √ Base year data is from the same population as to be included in the waiver. **Some Tidewater data based on the statewide data.**

2. __ Base year data is from a comparable population to the individuals to be included in the waiver. (Include a statement from an actuary or other explanation which supports the conclusion that the populations are comparable.)

III. Without Waiver Data Sources and Adjustments: Appendix D.III.

Purpose: To explain the data sources and reimbursement methodology for base year costs.

To identify adjustments which must be made to base year costs in order to arrive at the UPL for capitated services and the without waiver costs for all waiver services.

NOTE: The data on this schedule will be used in preparing **Appendix D.IV Without Waiver Cost Development**. Also, it is acceptable to use encounter data or managed care experience to develop with waiver costs or set capitated rates (see Section D.V). At this time, it is not acceptable to use experience data to develop without waiver costs. A workgroup has been formed to examine this policy. This submittal will be updated based upon the outcome of that workgroup.

NOTE: If the State is proposing to use a different methodology for Years 3 and 4 than were used in Years 1 and 2, please document all differences between the methodologies.

Regional Offices approve annual UPLs and contract rates developed by States. They are authorized to approve UPLs and contract rates that fall under the methodologies granted under the original and subsequent waiver authority. Modifications to the UPL development methodology should be approved through a waiver modification as explained in the instructions to this submittal.

Step 5: Actual cost and eligibility data are required for base year PMPM computations. Specify whether the base year is a State fiscal year (SFY), Federal fiscal year (FFY), or other period. **Please note the waiver years that this methodology was in place. Submit separate Appendix D.III charts if different methodologies or services were used in the Without Waiver costs for the upcoming waiver period than in the previous waiver period.** Please provide an explanation in the space below if: a) multiple years are used as the base year; or b) data from sources other than

the State's MMIS are used.

Step 6: See instruction box. This chart should be identical to the chart in Section A.III.d.1.

Step 7: **UPL Adjustments:** On Appendix D.III check all adjustments that apply to base year data.

Step 8. **Fee-For-Service Wraparound Cost Adjustments**: See instruction box.

Instructions For Steps 7 and 8 above:

Required Adjustments a. through g. (below) and Appendix D.III must be completed by all States. Optional Adjustments a. through l. (below) should be completed if the adjustment applies to your State. For each Optional Adjustment that does not apply, the State should note if they have made a policy decision to not include that adjustment. If the State has made an adjustment to its without waiver cost, information on the basis and methodology information below must be completed and mathematically accounted for in Appendix D.IV. All adjustments may be computed on a statewide basis, although some (e.g. reinsurance, stop/loss) may be specific to certain contracts and should be noted where appropriate. Similarly, some adjustments will apply to all services and to all eligibility categories while others will only apply to specific services provided to distinct eligibility categories. Again, it is very important to complete this preprint and Appendices D.III and D.IV as necessary to account for the proper methodology used by the State to calculate the UPL.

Describe below the methodology used to develop each adjustment. Prior approval is necessary for methodologies that are not listed as an optional check-off. Please note on each adjustment if the methodology is proprietary to the actuary. Note: CMS's intent is that if an accepted methodology is used (i.e., is one of the check-offs) and the size of the adjustment is noted in the Appendices and appears reasonable, then no additional documentation would be required for the waiver application. However, the CMS RO may require more documentation during the UPL and contract rate approval process.

Please note the waiver years that each adjustment was in place if the adjustment was not made for all four years. Submit separate Appendix D.IV charts for each year in the Without Waiver costs for the previous and upcoming waiver period.

Previous Waiver Period

a.___ During the last waiver period, the methodology used to calculate cost-effectiveness was different than described in the waiver governing that period. The differences were:

Please note the date of any methodology change and explain any methodology changes in this preprint. See also Step 5.

Upcoming Waiver Period -- For all three subsets of adjustments (Without Waiver Response required, Optional, and With Waiver Cost Adjustments) in this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response.

State Response to These Adjustments Is Required

a. Disproportionate Share Hospital (DSH) Payments: Section 4721 of the BBA specifies that DSH payments must be made solely to hospitals and not to MCOs/PHPs. Therefore, DSH payments are not to be included in cost-effectiveness calculations. Section 4721(c) does permit an exemption to the direct DSH payment. If this exemption applies to the State, please identify and describe in the Other Block.

1._√_ We assure CMS that DSH payments are excluded from base year data.
2.___ We assure CMS that DSH payments are excluded from adjustments.
3.___ Other (please describe):

b. Incurred but not Reported (IBNR) (Appendix D.III, Line 47): Due to the lag between dates of service and dates of payment, completion factors must be applied to data to ensure that the base data represents all claims incurred during the base year. The IBNR factor increases the reported totals to an estimate of their ultimate value after all claims have been reported. Use of at least three years is recommended as a basis.

Basis:

1.√**_ IBNR adjustment was made. Please indicate the number of years used as basis **three (3) years**.
   i.___ Claims in base year data source are based on date of service.
   ii.___ Claims in base year data source are based on date of payment.

2._**_IBNR adjustment was not necessary (Please explain).

Methodology:

1.√**_ Calculate average monthly completion factors and apply to the known paid total to derive an overall completion percentage for the base period.
2.___ Other (please describe):

c. Inflation (Appendix D.III, Line 48): This adjustment reflects the expected inflation in the FFS program between the Base Year and Year One and Two of the waiver. Inflation adjustments may be service-specific and expressed as percentage factors. States should use State historical FFS inflation rates.

Basis:

1. √ State historical inflation rates
   (a) Please indicate the years on which the rates are based: Inflation base years **FY 1999 – FY 2001** .
   (b) Please indicate the mathematical methodology used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.): **Least Squares Regression**

2. ___ Other (please describe):

d. Third Party Liability(TPL) (Appendix D.III, Line 61): This adjustment should be used only if the State will not collect and keep TPL payments for post-pay recoveries. If the MCO/PHP will collect and keep TPL, then the Base Year costs should be reduced by the amount to be collected.
Basis and methodology:
1. √ No adjustment was necessary
2. ___ Medicaid Management Information System (MMIS) claims tapes for UPL and rate development were cut with post-pay recoveries already deducted from the database.
3. ___ State collects TPL on behalf of MCO/PHP enrollees
4. ___ The State made this adjustment:
5. ___ Post-pay recoveries were estimated and the base year costs were reduced by the amount of TPL to be collected by MCOs/PHPs.
6. ___ Other (please describe):

e. FQHC and RHC Cost-Settlement Adjustment (Appendix D.III, Line 46) : This adjustment accounts for the requirement of States to make supplemental payments for the difference between the rates paid by an MCO/PHP to an FQHC or RHC and the reasonable costs of the FQHC or RHC. The UPL and capitated rates should include payments for comparable non-FQHC or non-RHC primary care service expenditures.

1. ___ Cost-settlement supplemental payments made to FQHCs/RHCs are included in without waiver costs, but not included in the MCO/PHP rates, base year UPL costs, or adjustments. The State also accounted for any phase-down in FQHC/RHC payments beginning in Fiscal Year 2000, as outlined by Section 4712 of the BBA. If the State pays a percentage of cost-settlement different than outlined in the BBA not to exceed 100 percent, please list the percentage paid _____. The UPL and capitated rates should include payments for comparable non-FQHC or non-RHC primary care service expenditures.
2. √ Other (please describe**): DMAS does make supplemental payments to make up the difference between what the MCO pays the clinic and what the clinic would receive from the State.**

f. Payments / Recoupments not Processed through MMIS (Appendix D.III, Line 51): Any payments or recoupments for covered Medicaid State Plan services included in the waiver but processed outside of the MMIS system should be included in the UPL.

1.√** Payments outside of the MMIS were made. Those payments include (please describe): **Additional payments were made to MCOs for newborns and eligibility reconciliation not included in the payment file and for a higher prevalence of high cost cases not reflected in the fee-for-service data for rate development.**

2.___ Recoupments outside of the MMIS were made. Those recoupments include (please describe):

3.**_ The State had no recoupments/payments outside of the MMIS.

g. Pharmacy Rebate Factor (Appendix D.III, Line 68): Rebates that States receive from drug manufacturers should be deducted from UPL base year costs if pharmacy services are included in the capitated base. If the base year costs are not reduced by the rebate factor, an inflated UPL may result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are under the waiver but not capitated.

Basis and Methodology:

1.√ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population.

2.___ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not prescribe drugs that are paid for by the State in FFS.

3.___ Other (please describe):

Optional Adjustments

Note: These adjustments may be made based upon the State's own policy preferences. There is no CMS preference for any of these adjustments. If the State has made an adjustment to its without waiver cost, information on the basis and methodology used is required and must be mathematically accounted for in Appendix D.IV. If the State has chosen not to make these adjustments, please mark the appropriate box.

a. Administrative Cost Calculation(Appendix D.III, Line 44): The administrative expense factor should include administrative costs that would have been attributed to members participating in the MCO/PHP if these members had been enrolled in FFS. Only those costs for which the State is no longer responsible should be recognized. Examples of these

costs include per claim claims processing costs, additional per record PRO review costs, and additional Surveillance and Utilization Review System (SURS) volume costs.

Basis:

1. _√_ All estimated administrative costs of the FFS plan that would be associated with enrolled managed care members if they had been enrolled in the FFS delivery system in this adjustment. This is equal to **two (2)** percent of FFS service costs.
2. ___ The State has chosen not to make adjustment.
3. ___ Other (please describe):

Methodology:

1. ___ Determine administrative costs on a PMPM basis by adding all FFS administrative costs and dividing by number of total Medicaid FFS members
2. _√_ Determine the percentage of medical costs that are administrative and apply this percentage to each rate cell.
3. ___ Other (please describe):

b. Copayment Adjustment (Appendix D.III, Line 45): This adjustment accounts for any copayments that are collected under the FFS program but not to be collected in the capitated program. States must ensure that these copayments are included in the UPL if not to be collected in the capitated program.

Basis and Methodology:

1. ___ Claims data used for UPL development already included copayments and no adjustment was necessary.
2. ___ State added estimated amounts of copayments for these services in FFS that were not in the capitated program.
3. _√_ The State has chosen not to make adjustment.
4. ___ Other (please describe):

c. Data Smoothing Calculations for Predictability (Appendix D.III, Line 65): Costs in rate cells are smoothed through a cost-neutral process to reduce distortions across cells and adjust rates toward the statewide average rate. These distortions are primarily the result of small populations, access problems in certain areas of the State, or extremely high cost catastrophic claims.

Basis and Methodology

1. ___ The State made this adjustment (please describe):

2. _√_ The State has chosen not to make adjustment.

d. Investment Income Factor (Appendix D.III, Line 50): This factor adjusts capitation rates and UPLs because FFS claims are paid after a service is provided while payments under managed care are made before the time

of services.

1.___ Since payments are made earlier, the equivalent amount of payment is slightly less, because the earlier payments would generate investment income between the date of receipts and the date of claim payment. A small reduction to the UPL was made. Factors to take into account include payment lags by type of provider; advances to providers; and the timing of payments to prepaid plans, relative to when services are provided.

2._√_ The State has chosen not to make adjustment.

3.___ Other (please describe):

e. PCCM case-management fee deduction (Appendix D.III, Line 52): When States transition from a PCCM program to a capitated program and use the PCCM claims data to create capitated UPLs, any management fees paid to the PCCM must be deducted from the UPL.

1._√**_ PCCM claims data were used to create capitated UPLs and management fees were deducted. Please note: if the State chose to use PCCM claims data, then this adjustment is required.

2.___ This adjustment was not necessary because the State used MMIS claims exclusive of any PCCM case-management fees.

3._**_ Other (please describe):

f. Pooling for Catastrophic Claims (Appendix D.III, Line 53): This adjustment should be used if it is determined that a small number of catastrophic claims are distorting per capita costs in some rate cells and are not predictive of future utilization.

Methodology:

1.___ The high cost cases' costs are removed from the rate cells and the per capita claim costs are distributed statewide across a relevant grouping of capitation payment cells. No costs are removed entirely from the rate cells, merely redistributed to rate cells in a manner that is more predictive of future utilization.

2._√_ The State has chosen not to make adjustment.

3.___ Other (please describe):

g. Pricing (Appendix D.III, Line 54): These adjustments account for changes in the cost of services under FFS. For example, changes in fee schedules, changes brought about by legal action, or changes brought about by legislation.

Basis:

1._√_ Expected State Medicaid FFS fee schedule increases between the base and rate periods.

2.___ The State has chosen not to make FFS price increases in the managed care rates.
3._**_ Changes brought about by legal action (please describe):
4._√_ Changes in legislation (please describe): **Adjustments were made for child and adult transplants, prescription drug rebates, and prostate screenings for persons age forty (40) and over who are at high risk for prostate cancer.**
5.___ Other (please describe):

h. Programmatic/policy changes (Appendix D.III, Line 55): These adjustments should account for any FFS programmatic changes that are not cost neutral and affect the UPL. For example, Federal mandates, changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit coverage of the FFS program.
Basis and Methodology:
1._√_ The State made this adjustment (please describe). **Adjustments were made for savings generated from the transportation broker program.**
2.___ The State has chosen not to make adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.

i. Regional Factors applied to Small Populations (Appendix D.III, Line 59): This adjustment is to be applied when there are a small number of eligible months in certain rate cells and large variations in PMPMs across these categories and regions exist.
Methodology:
1.___ Regional factors based on eligible months are developed and then applied to statewide PMPM costs in rate cells for small populations. This technique smooths out wide fluctuations in individual rate cells in rural states and some populations, yet ensures that expenditures remain budget neutral for each region and State.
2._√_ The State has chosen not to make adjustment.
3.___ Other (please describe):

j. Retrospective Eligibility (Appendix D.III, Line 60): States that have allowed retrospective eligibility under FFS must ensure that the costs of providing retrospective eligibility are not included in the UPL. The rationale for this is that MCOs/PHPs will not incur costs associated with retrospective eligibility because capitated eligibility is prospective. Please note, however, that newborns need not be removed from the base year costs if the State provides

retrospective eligibility back to birth for newborns.
Basis and Methodology:

1.____Compare the date that the enrollee was determined Medicaid-eligible by the State to the date at which Medicaid-eligibility became effective. If the effective date is earlier than the eligibility date, then the costs for retrospective eligibility were removed.
2._√_ The State has chosen not to make adjustment because it was not necessary given the State's enrollment process.
3.___ Other (please describe):

k. Utilization (Appendix D.III, Line 62): This adjustment reflects the changes in utilization of FFS services between the Base Year and the beginning of the waiver and between Years One and Two of the waiver.

1._√_ The State estimated the changes in technology and/or practice patterns that would occur in FFS delivery, regardless of capitation. Utilization adjustments made were service-specific and expressed as percentage factors.
2.___ The State has chosen not to make adjustment.
3.___ Other (please describe):

l. Other Adjustments including but not limited to guaranteed eligibility and risk-adjustment (Appendix D.III, Line 63). If the State enrolls persons with special health care needs, please explain by population any payment methodology adjustments made by the State for each population. For example, CMS expects States to set rates for each eligibility category (i.e., the State should set UPLs and rates separately for TANF, SSI, and Foster Care Children). Please list and describe the basis and methodology:

Step 9: **With Waiver Cost Adjustments** (in addition to the Capitated or FFS Base Year Cost Adjustments), Appendix D.III, Lines 70-72). Note: Costs for the following adjustments are included in the With Waiver Costs Appendix D.V.

a. Reinsurance or Stop/Loss Coverage (Appendix D.III, Line 71): Please note whether or not the State will be providing reinsurance or stop/loss coverage. Reinsurance may be provided by States to MCOs/PHPs when MCOs/PHPs exceed certain payment thresholds for individual enrollees. Stop loss provisions usually set limits on maximum days of coverage or number of services for which the MCO/PHP will be responsible. If the State plans to implement either reinsurance or stop/loss, a description of the methodology used is required. The State must document the probability of incurring costs in excess of the stop/loss level and the frequency of such occurrence based on FFS experience. The rate of

expenses per capita should be deducted from the capitation year projected costs. In the initial application, the effect should be neutral. In the renewal report, the actual reinsurance cost and claims cost should be reported in with waiver costs.

Basis and Methodology:

1. _√_ The State does not provide reinsurance or stop/loss for MCOs/PHPs, but requires MCOs/PHP to purchase such coverage privately. No adjustment was necessary.
2. ___ The State provides reinsurance or stop/loss (please describe):

b. Incentive/bonus payments (Appendix D.III, Line 72): This adjustment should be applied if the State elects to provide incentive payments in addition to capitated payments under the waiver program. The State must document the criteria for awarding the incentive payments, the methodology for calculating incentives/bonuses, and the monitoring the State will have in place to ensure that total payments to the MCOs/PHPs do not exceed the UPL. The costs associated with any bonus arrangements must be accounted for in Appendix D.V With Waiver costs. Please describe the criteria for awarding incentive payments, the methodology for calculating bonus amounts, and the monitoring the State will have in place to ensure that total payments to MCOs/PHPs do not exceed the UPL:

c. Other Adjustments (Please list and describe the basis and methodology):

IV. Without Waiver Development: Appendix D.IV

Purpose: To calculate without waiver costs on a PMPM basis.

NOTE: CMS will measure the cost effectiveness of the waiver in the renewal based on this PMPM calculation and the actual enrollment under the waiver.

Please note that the data in this section for Waiver Years 1 and 2 should reflect the PMPM Without Waiver costs that were approved in the previous waiver in your renewal, plus any changes approved by the RO in the annual capitated rate approval. Please submit separate Appendix D.IV charts for each year in the Without Waiver costs for the previous and upcoming waiver period.

Step 10: See instruction box.

Step 11: See instruction box. These rate cells must be identical to the rate cells used in Appendix D.II Member Months.

Steps 12-13: See instruction boxes.

Step 14: See instruction box. Adjustments expressed as percentages are applied to the base year amount by category of service.

Steps 15-16: See instruction boxes.

Step 17: See instruction box. Step 17 is designed to incorporate the cost of FFS wraparound services into the without waiver costs. To simplify presentation, the State may combine all wraparound services listed at Appendix D.III, presenting them as one base year amount per rate cell. The State may then combine all adjustment factors which affect a given rate cell, and apply the adjustments accordingly. This methodology will result in a subtotal of adjusted FFS costs applied to each rate cell. If the State prefers, individual FFS wraparound services may be calculated on Appendix D.IV, as illustrated with pharmacy services in the example (Columns Z-AF). If adjusted FFS costs are material, the State should be prepared to explain the adjustments upon request.

Step 18: See instruction box. These amounts represent the final PMPM amounts which will be applied to actual enrollment in measuring cost effectiveness. States will not be held accountable for caseload changes when submitting their waiver renewal cost-effectiveness calculations. States should have PMPM costs for the 2-year period equal to or less than projected Without Waiver costs as calculated in Step 18.

V. With Waiver Development: Appendix D.V

Steps 19-29

The actuarial basis for the capitation rates for both MCOs and PHPs must be specified in the waiver application, and there must be a demonstration that payments to the contractor will be on an actuarially sound basis, in accordance with the regulations at 42 CFR 434.61. The capitation rates must be specified in the waiver application. Specifying the "actuarial basis" of the capitation rate means providing a description of the methodology the State uses to determine its capitation rate(s). Among the possible methods a State might use are: a percentage of the UPL; a budget-based rate (e.g., the MCO/PHP's cost); and the contractor's community rate with adjustments as appropriate (e.g., for the scope of services in the State's contract and the utilization characteristics of the Medicaid enrollees). **Please see attached rate report titled “Options and Medallion II Data Book and Capitation Rates, Fiscal Year 2003”.**

You may use other methods as well. If there are adjustments for stop-loss and

reinsurance arrangements, the actuarial basis for these adjustments should be documented. The important things to remember are that the rate methodology must be specified and there must be a demonstration that the rates do not exceed the UPL.

Finally, as specified in 42 CFR 447.361, payments to contractors must be no more than the cost of providing those same services on a FFS basis, to an actuarially equivalent nonenrolled population group (i.e., no greater than the UPL).

With waiver costs are the sum of payments to capitated providers, FFS payments for managed care enrollees that are controlled or affected by managed care providers, and the costs to the State of implementing and maintaining the managed care program.

a. Please mark and complete the following assurances to HCFA:

1. _√_ The State assures CMS that the capitated rates will be equal to or less than the UPL based upon the following methodology. Please attach a description of the rate setting methodology and how the State will ensure that rates are less than the UPL if the State is not setting rates at a percent of UPL.
   - (a)_√_ Rates are set at a percent of UPL
   - (b)__ Negotiation (please describe):
   - (c)__ Experience-based (contractor/State's cost experience or encounter data) (please describe):
   - (d)__ Adjusted Community Rate (please describe):
   - (e)√** Other (please describe): **A $1.50 PMPM was added to the rates for expansion areas for first year start-up costs ending 11/30/02.**

2. _√_ The rates were set in an actuarially sound manner. Please list the name, organizational affiliation of the actuary used, and actuarial attestation of the initial capitation rates. **Price WaterhouseCoopers, Inc.**

3. _√_ The State will submit all capitated rates to the CMS RO for prior approval.

b.___ The State is requesting a 1915(b)(3) waiver in section A.II.g.2 and will be providing non-state plan medical services. **Virginia does not have a 1915(b)(3) waiver.**

1. ___ The State will be spending a portion of its savings above the capitation rates for additional services under the waiver.

Please state the actual amounts spent on 1915(b)(3) savings which was spent on additional services in the previous waiver period_____. This amount must be built into the State's with waiver costs for Years 1 and 2.

Please state the PMPM or aggregate amount of 1915(b)(3) savings which will be spent on additional services in the upcoming waiver period_____. This amount must be built into the State's with waiver costs for Years 3 and 4.

2.___ The State is requiring plans to spend a portion of their capitated rate on additional non-State plan medical services.

Please state the actual amount or percent of the PMPM that was spent on average on non-State plan covered medical services_____. This amount must be built into the State's with waiver costs as a portion of the capitated rates. Please document the actual amount spent on non-State plan medical services.

Please estimate the amount or percent of the PMPMs that will be spent on average on non-State plan covered medical services_____. This amount must be built into the State's with waiver costs as a portion of the capitated rates. Please explain the assumptions that the State used to calculate this amount.

Steps 19-20: See instruction boxes. The eligibility categories and rate cells must agree with those in Appendix D.IV. States must document actual PMPM costs under the waiver for the previous two-year period. They also must estimate the PMPM costs under the upcoming waiver period. **Please note that the data in this section for Waiver Years 1 and 2 should reflect the actual costs incurred in the previous waiver period under the Waiver Program. Please submit separate Appendix D.IV charts for each year in the Without Waiver costs for the previous and upcoming waiver period.** Note: because of the timing of the waiver renewal submittal, the State may need to estimate up to six (6) months of enrollment data for Year 2 of the previous waiver period.

Steps 21-29: See instruction boxes.

VI. Year 1 Aggregate Costs: Appendix D.VI

See Instructions for C.VII Year 2 Aggregate Costs

VII. Year 2 Aggregate Costs: **Appendix D.VII**
Steps 30-35: See instruction boxes.

VIII. Year 3 Aggregate Costs: **Appendix D.VIII**
See Instructions for C.VII Year 2 Aggregate Costs

IX. Year 4 Aggregate Costs: **Appendix D.IX**
See Instructions for C.VII Year 2 Aggregate Costs

X. Cost Effectiveness Summary: Appendix D.X
Steps 36-40: See instruction boxes.

Section E. Fraud and Abuse

States can promote the prevention, detection, and reporting of fraud and abuse in managed care by ensuring both the State and the MCOs/PHPs have certain provisions in place.

Previous Waiver Period

a.___ During the last waiver period, the program's fraud and abuse requirements operated differently than described in the waiver governing that period. The differences were:

b. [Required for all elements checked in the previous waiver submittal] Please provide summary results from all fraud and abuse monitoring activities, including a summary of any analysis and corrective action taken, for the previous waiver period [items E.I-II of 1999 initial preprint; relevant sections of 1995 preprint].

Upcoming Waiver Period -- Please check all items below which apply, and describe any other measures the State takes. For all items in this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response.

I. State Mechanisms

a. √ The State has systems to avoid duplicate payments (e.g., denial of claims for services which are the responsibility of the MCO/PHP, by the State's claims processing system).

b.___ The State has a system for reporting costs for non-capitation payments made in addition to capitation payments (e.g., where State offered reinsurance or a stop/loss limit results in FFS costs for enrollees exceeding specified limits)

c.___ The State has in place a formal plan for preventing, detecting, pursuing, and reporting fraud and abuse in the managed care program in this waiver, which identifies the staff, systems, and other resources devoted to this effort. Please attach the fraud and abuse plan.

DMAS addresses the potential for fraud and abuse in the managed care program in a number of ways. As stipulated in the Medallion II contract, DMAS requires the following regarding access to and retention of records, access to MCO facilities, reporting of annual audit findings, and contract monitoring:

<u>Access to Records</u>

DMAS and its duly authorized representatives must have access to any books, fee schedules, documents, papers, and records of the MCOs and any of their subcontractors or network providers. DMAS or its duly authorized representatives are allowed to inspect, copy, and audit any medical and/or financial records of the MCOs, their subcontractors, and their network providers.

Retention of Records

All records and reports relating to the contract are to be retained by the MCOs for a period of five (5) years after final payment is made under the contract or, in the event that the contract is renewed, for a period of five (5) years after the renewal date. However, when an audit, litigation, or other action involving records is initiated prior to the end of said period, records will be maintained for a period of five (5) years following resolution of such action.

Copies of the documents on microfilm or other appropriate media may be substituted for the originals provided that the microfilming or other duplicating procedures are reliable and are supported by an effective retrieval system which meets legal requirements to support litigation and to be admissible as evidence in any court of law.

Access to Premises

The MCOs must allow duly authorized agents or representatives of the state or federal government, during normal business hours, access to the MCOs' premises, the subcontractors' premises, or the premises of the MCOs' network providers to inspect, audit, monitor, or otherwise evaluate the performance of the MCOs', subcontractors', or network providers' contractual activities and must produce all records requested as part of such a review or audit.

In the event right of access is requested under this section, the MCOs, subcontractors, or network providers must provide, upon request, and make available adequate space on the premises to reasonably accommodate the state or federal personnel conducting the audit or inspection and staff to assist in the audit or inspection effort. All inspections or audits will be conducted in a manner that will not unduly interfere with the performance of the MCOs', subcontractors',

or network providers' activities. The MCOs will be given thirty (30) calendar days to respond to any preliminary findings of an audit before DMAS will finalize its findings. All information so obtained will be accorded confidential treatment as provided under applicable law.

DMAS, the Office of the Attorney General of the Commonwealth of Virginia, the U.S. Department of Health and Human Services, and/or their duly authorized representatives will be allowed access to evaluate, through inspection or other means, the quality, appropriateness, and timeliness of services performed under the contract.

Annual Audit by Independent Auditor

The MCOs must provide DMAS with a copy of its annual audit report as required by the Bureau of Insurance of the Commonwealth of Virginia at the time it is submitted to the Bureau of Insurance.

DMAS also reserves the right to require MCOs to engage the services of an outside independent auditor to conduct a general audit of the MCOs' major managed care functions performed on behalf of the Commonwealth. The MCOs must provide DMAS with a copy of the audit within thirty (30) calendar days of completion of the audit.

Contract Monitoring

DMAS is responsible for conducting an ongoing contract monitoring process. As part of this monitoring process, DMAS reviews the performance of the MCOs in relation to the performance standards outlined in the contract, in the proposal submitted in response to the RFP, and in the RFP.

DMAS, at its sole discretion, may conduct any or all of the following activities as part of the contract monitoring process:

- **Collect and review standard hard copy and electronic reports and related documentation including encounter data which the MCOs, under the terms of the contract, are required to submit to DMAS or otherwise maintain;**

- **Conduct MCO, network provider, and subcontractor**

site visits; and

- **Review MCO policies and procedures and other internal documents.**

While conducting contract monitoring activities, DMAS may assess the MCOs' compliance with any requirements set forth in the contract and in the documents referenced within the contract.

d.___ The State has a specific process for informing MCOs/PHPs of fraud and abuse requirements under this waiver. If so, please describe.

e.___ Other (please describe):

II. MCO/PHP Fraud Provisions

a. √ The State requires MCOs/PHPs to have an internal plan for preventing, detecting, and pursuing fraud and abuse. Please describe any required fraud and abuse plan elements.

As stipulated in the Medallion II contract, the MCOs must have in place policies and procedures for ensuring protections against actual or potential fraud and abuse. The MCOs must have a detailed Program Integrity Plan (PIP). The Program Integrity Plan must define how the MCOs will adequately identify and report suspected fraud and abuse by enrollees, by network providers, by subcontractors, and by the MCOs. The Program Integrity Plan must discuss the monitoring tools and controls necessary to protect against theft, embezzlement, or other types of fraud and program abuse and describe the type and frequency of training that will be provided to detect fraud. All fraudulent activities or other program abuses must be subject to the laws and regulations of the Commonwealth of Virginia and/or federal laws and regulations. The MCOs have been provided contact names within DMAS and the correct protocol for reporting suspected member and provider fraud and abuse.

The MCOs' Program Integrity Plan must address the following requirements:

1) Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all

applicable Federal and State standards.

2) **The designation of a compliance officer and a compliance committee that are accountable to senior management. The compliance officer is responsible for coordinating internally and with DMAS on any fraud or abuse case. The MCOs may identify different contact people for enrollee fraud and abuse, network provider fraud and abuse, subcontractor fraud and abuse, and MCO fraud and abuse.**

3) **Effective training and education for the compliance officer and the organization's employees.**

4) **Effective lines of communication between the compliance officer and the organization's employees.**

5) **Enforcement of standards through well-publicized disciplinary guidelines.**

6) **Provision for internal monitoring and auditing.**

7) **Provision for prompt response to detected offenses and for development of corrective action initiatives relating to the MCO's contract.**

The MCOs must provide information and a procedure for enrollees, network providers, and subcontractors to report incidents of potential or actual fraud and abuse to the MCO and to the Commonwealth. The MCOs must report all potential or actual fraud and abuse to DMAS or the Virginia Bureau of Insurance.

The MCOs must report incidents of potential or actual fraud and abuse to DMAS within forty-eight (48) hours of initiation of any investigative action by the MCOs, or within forty-eight (48) hours of MCO notification that another entity is conducting such an investigation of the MCO, its network providers, or its enrollees.

The MCOs must cooperate with all fraud and abuse investigation efforts by DMAS and other state and federal offices.

b.__√__ The State requires MCOs/PHPs to report suspected fraud and cooperate with State (including Medicaid Fraud Control Unit)

investigations.

DMAS requires MCO reporting on suspected subcontractor, provider, or enrollee fraud and abuse within 48 hours of notification of the conduct of an investigation by another organization or within 48 hours of the initiation of an internal investigation.

The MCOs have been provided contact names within DMAS and the correct protocol for reporting suspected member and provider fraud and abuse.

Section F. Special Populations

States may wish to refer to the October 1998 HCFA document entitled “Key

Approaches To The Use of Managed Care Systems For Persons With Special Health Care Needs" as guidance for efforts to ensure access and availability of services for persons with special needs. To a certain extent, key elements of that guide have been incorporated into this waiver application form.

I. General Provisions for Special Populations

Previous Waiver Period

a.___ During the last waiver period, the program operated differently for special populations than described in the waiver governing that period. The differences were:

b. [Required for all elements of applicable sections checked in the previous waiver submittal] Please provide results from all monitoring efforts for each subpopulation noted in the previous waiver, including a summary of any analysis and corrective action taken, to determine the level of compliance with State requirements in the area of special populations for the previous waiver period [items F.I.a-g of the 1999 initial preprint; as applicable in 1995 preprint].

(Section F.1.a.) – The State is committed to the SSI and Title V populations. Service access and quality delivered to these populations were monitored in four ways:

- **Evaluation of complaints**
- **Evaluation of reports from the CAHPS survey**
- **Evaluation of reports from the Immunization Study**
- **Evaluation of disenrollment reports (which studies the movement between plans**

(Section F.1.b.) See above.

(Section F.1.c.) DMAS has taken a proactive role in the training of its contracted MCOs regarding special needs populations. Emphasis was placed on the identification of these special needs recipients as well as accessibility, continuity, and quality of the services provided to them and improved health outcomes. As a result of the State's concentrated efforts, each MCO has implemented prenatal and asthma programs, which have resulted in a decrease in emergency room visits, as well as other individualized programs such as the Life Coach Program for Schizophrenia (Sentara Family Care). See Attachment F.I.b. During the waiver period, significant progress was made in the coordination and collaboration of agencies that serve special needs clients. These efforts, which

are outlined in more detail below, were for the purpose of improving service access and quality, for identifying duplication of services among the various organizations, and for identifying service gaps among the multiple service providers.

DMAS held periodic Managed Care Advisory Meetings (MAC) that included both consumer and agency representation. The MAC provided a forum for discussion of special needs issues. The MAC committee consists of representatives from the Virginia Pharmacists Association, Virginia Primary Care Associates, MCV Hospitals, Medical Society of Virginia, Virginia Association of Health Plans, Virginia Department of Health (VDH), Community Care Network of Virginia (representing rural health), Virginia Institute for Developmental Disabilities, UVA Health Services Foundation, UVA Medical Center, Virginia Poverty Law Center, Community Health Associates Physician Organization (local physician group), Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS), Virginia Department of Social Services (DSS), Center for Pediatric Research of Eastern Virginia Medical School, and the MCOs participating in Medallion II.

Also during this waiver period, DMAS, along with the VDH, co-chaired the Prenatal Infant, Children, and Special Needs Group (PIC) meetings. The goal of this committee was to improve access to prenatal care, address issues of children with special needs, and provide a forum for special needs populations. This group included representatives from DMAS and other State agencies such as VDH, DSS, DMHMRSAS, and the MCOs participating in Medallion II.

DMAS held periodic case managers' meetings which focused on special needs populations. The goal of these meetings was to facilitate communication and care coordination between community case managers/providers and the case managers working for the MCOs. These meetings, which addressed topics such as Children with Special Health Care Needs and transition issues for special needs recipients (during the expansion phase), were well-attended by MCO case managers, local health departments, social service and Community Service Board representatives, Title V program representatives, Early Intervention program representatives, personnel from hospitals, clinics, provider offices, legal aid

advocates, etc. An important tool distributed during these meetings was the Managed Care Resource Guide which was compiled and updated by the State. See Attachment F.I.b.

In addition to the meetings listed above, staff from DMAS have met routinely with staff from Department of Mental Health, Mental Retardation and Substance Abuse Services (Part C) and from the Virginia Department of Health (Care Coordination for Children – Title V). The goal of these meetings was to increase collaboration and open communication between the agencies and identify service gaps or service duplications within the various agencies. These collaboration efforts have proven successful through the creation of the Title V report which DMAS receives monthly from VDH and shares with the MCOs (Attachment F.I.b.), through the development of the complaint tracking report which is submitted to DMAS by Early Intervention providers when there are any service barriers (Attachment F.I.b.), and through the consistent attendance rates at the MAC, PIC, and case managers' meetings offered by DMAS. See Attachment A.I.

(Section F.I.d.) – See above.

Section (F.I.e.) During the waiver period, DMAS monitored access to services, quality of care, coordination of care, and enrollee satisfaction via activities performed by DMAS contract monitors and the contracted external quality review organization (EQRO). State activities included: provider network analyses, monitoring of complaint and disenrollment reports (Complaints for these special populations were found to be low.), monitoring of grievances and appeals, evaluation of HEDIS measures, evaluation of results from the MCOs' Consumer Assessment of Health Plans Surveys (CAHPS), review of recipient communication materials prior to mailing, and establishment of procedures for case management of high risk prenatal mothers and infants.

EQRO activities included clinical focus studies; recipient surveys to assess service access, quality, and care coordination; review of complaints, grievances, and appeals; and review of utilization management policies and procedures. Listed below are the results of the EQRO's monitoring activities.

In the Fall of 2001, WB&A Market Research, a subcontractor of

Delmarva Foundation, Inc., DMAS' contracted EQRO, performed the CAHPS on a sample of adults and children in the managed care and fee-for-service programs. A separate sample of children who were in the eligibility category of SSI and those receiving services paid with Title V funds was drawn. Following are the responses to key items from this population enrolled in Medallion II.

Respondents were asked to rate their providers on a scale of zero to 10, with ten the best rating. Table 1 displays these results.

Table 1. Percent Rated Seven or Better

Provider	Percent
Personal Doctor	88%
Specialist	93%
Quality of Care	93%
Health Plan	86%

Table 2. Getting Needed Care

Item	Response
Getting personal doctor or nurse	95% no problem
Getting referral to specialist	87% no problem
Getting care believed necessary	86% no problem
Delays in care while waiting approval	84% no problem
Composite Score	88% no problem

Table 3. Getting Care Quickly

Item	Response
Got needed help or advice	90% usually or always
Got appt. for routine care	89% usually or always
Got care for injury or illness	93% usually or always
Waited < 15 minutes past appt. time	71% usually or always
Composite	86% usually or always

Table 4. How Well Doctors Communicate

Item	Response
Listened carefully	98% usually or always

Explained in way they understand	92% usually or always
Showed respect	95% usually or always
Spent enough time	87% usually or always
Composite	93% usually or always

Table 5. Courteous & Helpful Office Staff

Item	Response
Courteous, helpful staff	96% usually or always
Helpful	96% usually or always
Treated with respect	95% usually or always
Composite	96% usually or always

Table 6. Health Plan Customer Service

Item	Response
Finding/understanding written materials	94% usually or always
Getting needed help when called	83% usually or always
Got help with paper work	75% usually or always
Composite	84% usually or always

Other results included the mean number of days recipients waited between making an appointment and seeing a provider for routine health care, which was 3.1, and the mean number of days recipients waited between making an appointment and seeing a provider for illness or injury, which was 0.9 days. In addition, 98% said that their doctor understands how the child's condition affects the child's day-to-day life, and 94% said their doctor understands how the condition affects the family's day-to-day life. Eighty-seven percent of respondents said they had no problem getting prescription medicine, and 41% said they had received care from a dental office. For other results, please refer to the CAHPS report, Attachment B.I.b.10.

In 2000, Delmarva Foundation, Inc. also conducted a study of immunization completion at two-years of age. Immunization completion is defined as completion of the series 4DPT/3 Polio/1 MMR. Sixty-nine percent of children in SSI and 70% in Title V had completed the series.

DMAS began receiving data identifying children receiving Title V services from the Virginia Department of Health and created

a system to track complaints and enrollment for the SSI/Title V population. In April 2002, there were 0.0171 complaints per 1,000 Title V enrollees and 0.0238 per 1,000 SSI enrollees. In addition, six out of a total of 585 Title V enrollees transferred MCOs during April 2002, and 109 out of 10,919 SSI enrollees transferred MCOs. See Attachment F.I.b.

(Section F.I.f.) The Medallion II contract included language requiring physical access to sites by persons with disabilities. Complaint reports were monitored to evaluate any complaints related to physical location accessibility.

(Section F.I.g.) The CAHPS contained specific performance measures as addressed in Section F.I.e. above. Complete results of this survey can be found in Attachment B.I.b.10.

The Immunization Study for the relevant populations also contained performance measures addressed in Section F.I.e. Complete results of this survey may be found in Attachment A.III.d.7.c.

All MCOs had preventive care programs in place for prenatal women, infants, and children.

c. Please describe the transition plan for situations where an enrollee with special health care needs will be assigned to a new provider when the current provider is not included in the provider network under the waiver.

The current MCO networks are extensive. All of the participating health plans have contractual arrangements with hospitals in the localities they serve including specialty facilities such as Children's Hospital in Richmond, Children's Hospital of King's Daughters in Tidewater, the University of Virginia Health Center in Charlottesville, and Virginia Commonwealth University's Medical College of Virginia in Richmond. Specialty hospitals such as these host numerous pediatric specialists, ancillary providers, and support systems and facilitate access to the best and most experienced health care providers in the region. DMAS reviews these networks annually to ensure that adequacy and accessibility standards, as set forth by the contract, are met.

Both DMAS and the MCOs understand the need for recipients with special health care needs to maintain consistency with

his/her known provider(s). The enrollment broker maintains comprehensive lists of PCPs and specialists for each plan. By sharing this information with recipients, the broker can assist the recipient in making a provider choice. The broker also completes a Health Status Assessment for each recipient enrolling or transferring between plans. These assessments are useful in identifying recipients with special needs.

In order to promote consistency of care, the Medallion II contract offers two options. First, the contract states: "Enrollees with disabling conditions, chronic illness, or child(ren) with special health care needs may request that their PCP be a specialist. The Contractor shall have in place procedures for ensuring access to needed services for these enrollees or shall grant these PCP requests as is reasonably feasible and in accordance with the Contractor's credentialing policies and procedures." The other option offered by the contract is: "The MCO must provide coverage out-of-network… for up to 30 days to transition the client to an in-network provider…".

DMAS has also developed a process of special individual (departmental) consideration for exemption of special needs recipients in order that they may maintain consistency in their care and service providers. This exemption would allow the recipients to request a change in MCO assignment, after open enrollment ends, in order to remain with a known provider. This process has been utilized on one occasion in order to allow an Early Intervention recipient to remain with his long-term therapy provider.

Upcoming Waiver Period -- For items a. through g. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Please check all items which apply to the State.

a. √ The State has a specific definition of "special populations" or "populations with special health care needs." The definition should include populations beyond those who are SSI or SSI-related, if appropriate, such as persons with serious and persistent mental illness, and should specify whether they include adults and/or children. Some examples include: Children with special needs due to physical and/ or mental illnesses, Older adults (over 65), Foster care children, Homeless individuals, Individuals with serious and persistent mental illness and/or substance abuse, Non-elderly adults who are disabled or chronically ill with developmental or

physical disability, or other. Please describe.

The Balanced Budget Act does not require specific populations to be defined as "special populations" or "populations with special health care needs." The State, however, defines its special populations as "Children with Special Health Care Needs" (CSHCN) . Children with Special Health Care Needs (CSHCN) include children under age 21 who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition(s) and may need health and related services of a type or amount over and above those usually expected for the child's age. CSHCN consist of children in the eligibility categories of SSI and Title V participation.

Virginia has concentrated its special needs populations in the categories of SSI and Title V because, unlike many other states, Virginia also participates in the 1915c Home and Community Based Services Waiver. The HCBS waiver targets specific populations that often overlap with the special needs populations identified above. Persons enrolled in the 1915c waiver in the Medallion II areas are exempt from mandatory managed care enrollments. Therefore, it appears that many of these special needs persons who are eligible for managed care have been enrolled into one of the following waiver services that Virginia offers:

- **AIDS/ARC**
- **Mental Retardation Services**
- **Consumer-Directed Personal Attendant Services**
- **Technology Assisted Services**
- **Elderly and Disabled**
- **Individual and Family Developmental Disability Support Waiver.**

Attachment F.I.a. contains information pertaining to Virginia's 1915c Waivers.

b. √ There are special populations included in this waiver program. Please list the populations.

- **SSI**
- **Title V**

c. √ The State has developed and implemented processes to collaborate and coordinate with, on an ongoing basis, agencies which serve

special needs clients, advocates for special needs populations, special needs beneficiaries and their families. If checked, please briefly describe.

Medicaid MCOs must coordinate services to ensure access to the full continuum of treatment and rehabilitative medical and outpatient mental health services. The MCOs are contractually required to coordinate services with the following:

- **Special education programs**
- **Child protective services**
- **Early intervention programs**
- **Mental health programs**
- **Developmental disabilities programs**
- **WIC, Head Start, community agencies, State agencies, safety net providers, and teaching institutions and facilities.**

The State is committed to promoting and providing accessible and quality health care services to recipients with special health care needs and continues to collaborate and coordinate with other agencies and advocates in multiple ways, such as: continued participation in the MAC and PIC meetings, continued presentation of periodic case manager meetings, and attendance at workshops such as the one co-sponsored by one of the MCOs (Sentara) entitled, "Medical Home Initiatives for Children with Special Health Care Needs".

DMAS chairs a committee entitled, "Prenatal Infants and Children with Special Health Care Needs" (PIC). The goal of this committee is to improve access to prenatal care, address issues of children with special needs, provide better coordination of programs and services for special needs populations, and to address duplication and gaps in available services. This group brings together representatives from DMAS and other State agencies such as VDH, DSS, DMHMRSAS, and the MCOs participating in Medallion II.

DMAS will continue to hold periodic MAC meetings which includes both consumer and agency representation. A description of this committee is in Section F.I.b.

DMAS will continue to convene periodic case managers' meetings throughout the State with topics pertinent to the attending participants. Meeting topics are often solicited from

the participants themselves. Meetings are attended by case managers from each of the plans, case managers from Title V and Part C programs, case managers and discharge planners from hospitals, personnel from local health departments, clinics, social services offices, Community Service Boards, etc. The goals of the case management meetings are to:

1) **Share information between DMAS, the health care plans, and service personnel working in the communities,**
2) **Help identify specific issues, and possibly individual cases, which need to be addressed by providers with a goal of better care coordination and increased problem solving capabilities, and**
3) **Encourage "networking" among case managers and health care personnel which leads to an increased awareness of available programs, options, and resources and allows special needs populations to be better served.**

Recipients with special health care needs have been presented as an annual topic, and with increased collaboration between agencies and resources, will continue to be a topic in high demand. Pregnancy issues, prenatal care, and pregnancy-related programs offered under each MCO are forthcoming requested topics.

A new initiative by DMAS will be participation with the Virginia Department of Health in their newly approved grant (July 2002) entitled, "Improving Access to Comprehensive Insurance Benefits and Services for Children with Special Health Care Needs (CSHCN)". The purpose of this grant/ program is to improve health outcomes for CSHCN by reducing health disparities and removing barriers to care. The grant will be piloted in two localities of the State and will partner with two of DMAS' currently contracted MCOs.

d. √ The State has programs/services in place which coordinate and offer additional resources and processes to ensure coordination of care among:

1. √ Other systems of care (Please specify, e.g. Medicare, HRSA Title V grants, Ryan White CARE Act, SAMHSA Mental Health and Substance Abuse Block Grant Funds)

Early Intervention Part C

2.___ State/local funding sources
3.___ Other (please describe):

e._√_ The State has in place a process for ongoing monitoring of its listed special populations by special needs subpopulation included in the waiver in the following areas:

1._√_ Access to services (please describe):

The Balanced Budget Act does not require monitoring of special populations. However, funds permitting, the State will include Title V and SSI children as part of the total Medallion II population monitoring in a Consumer Assessment of Health Plans Survey (CAHPS)

2._√_ Quality of Care (please describe):

The Balanced Budget Act does not require monitoring of special populations. The State, however, will include Title V and SSI children as part of the total Medallion II population in its immunization compliance rate of two-year-old children and the adequacy of prenatal care for women in the eligibility category of Supplemental Security Income.

3._√_ Coordination of care (please describe):

The Balanced Budget Act does not require monitoring of special populations. The State, however, will include Title V and SSI children as part of the total Medallion II population as part of its review of monthly enrollment statistics, monitoring of complaints from a variety of sources (the enrollment broker, Managed Care Helpline, DMAS' Managed Care Division staff through calls and letters to the Director, Secretary, and/or the Governor), and good cause disenrollments.

4._√_ Enrollee satisfaction (please describe):

The Balanced Budget Act does not require

monitoring of special populations. However, if budget permits, the State will include Title V and SSI children as part of the total Medallion II population in a CAHPS survey

5. √** Other (please describe):

DMAS has a comprehensive monitoring system for all enrollees in MCOs. Each MCO is reviewed annually by an independent contractor. The contractor reviews the following areas:

- **Medical and Utilization Management**
- **Quality Assurance and Improvement Programs**
- **Member Services and Grievance and Appeals Processes**
- **Management Information Systems**

For each of these functions, there are detailed criteria based on regulatory requirements from CMS, the Code of Virginia, the current NCQA standards, the Medallion II contract, the Virginia Bureau of Insurance, and the Virginia Department of Health requirements for Managed Care Health Insurance Plans (MCHIP) Licensees.

This review includes the entire MCO-enrolled Medicaid population to ensure that all enrollees have access to services, are assured the highest possible level of quality and coordination of care, and that all enrollees are satisfied.

The analysis of complaints from the MCOs, the enrollment broker, the Managed Care Division at DMAS, and DMAS' Helpline offers another tool for performance monitoring.

In addition, DMAS has an exemption process in place for Part C Early Intervention children when it is found that they are unable to get required services. To date, however, there have been no requests for this action. (Attachment A.III.b.4.i.)

f. √ The State has standards or efforts under way regarding a location's physical Americans with Disabilities Act (ADA) access compliance

for enrollees with physical disabilities. Please briefly describe these efforts, and how often compliance is monitored.

The Medallion II contract requires that MCOs must "assure physical and program accessibility of all services to persons with physical and sensory disabilities pursuant to ξ504 of the Federal Rehabilitation Act of 1973, as amended ((29) U.S.C. 794) and with all requirements imposed by applicable regulations…. In the Americans with Disabilities Act…". A routine analysis of complaints includes any reference to physical access issues. To date, none have been received.

g. √ The State has specific performance measures and performance improvement projects for their populations with special health care needs. Please identify the measures and improvement projects by each population. Please list or attach the standard performance measures and performance improvement projects:

The Balanced Budget Act does not require monitoring of special populations. The State, however, will include Title V and SSI children as part of the total Medallion II population and has specific measures for the immunization compliance rate for two-year old children. The inclusion criteria are the achievement of two years of age during the study period and six months of continuous enrollment in a Medicaid program. The definition of completely immunized is completion of the 4:3:1 series, and the target rate is 85%.

II. State Requirements for MCOs/PHPs

Previous Waiver Period

a.___ During the last waiver period, the program operated differently for special populations than described in the waiver governing that period. The differences were:

b. [Required for all elements checked in the previous waiver submittal] Please provide results from all monitoring efforts for each subpopulation noted in the previous waiver, including a summary of any analysis and corrective action taken, to determine the level of compliance with State requirements in the area of special populations for the previous waiver period [items F.II.a-h of the 1999 initial preprint; as applicable in 1995 preprint].

(Section F.II.a.) - The MCO contract stipulated that each participating MCO must have in place a primary care system of care delivery that uses a coordinated and continuous case management approach in order to minimize fragmentation of care, reduce barriers, and link enrollees with special needs to appropriate services to ensure comprehensive, continuous health care. The MCO site visits, which were conducted in May 2002, verified that all MCOs have in place the mechanisms to provide these case management/care coordination services. DMAS monitored the MCOs through their utilization reports and their pregnancy and infant programs.

(Section F.II.b.) – DMAS monitored MCO networks through quarterly reports, annual reviews by Delmarva, and at the RFP level.

The MCOs are required to have access to specialists and other "safety net" providers. If the MCO network does not contain a needed specialty provider, the MCO must find and provide for those services utilizing out-of-network providers. In addition to monitoring provider networks, DMAS also monitored complaint reports for specialty access issues.

(Section F.II.d.) – The Medallion II contract states: "Enrollees with disabling conditions, chronic illnesses, or child(ren) with special health care needs may request that their PCP be a specialist. The Contractor shall have in place procedures for ensuring access to needed services for these enrollees or shall grant these PCP requests as is reasonably feasible and in accordance with Contractor's credentialing policies and procedures."

(Section F.II.e.) – DMAS collected data on complaints and disenrollments for the SSI and Title V populations. Title V identification lists were also received from the Virginia Department of Health and shared with the MCOs on a monthly basis. In addition, DMAS provided to the MCOs enrollment information which identified children by age, SSI adults, and individuals who were pregnant.

(Section F.II.g.) – The MCOs utilized prior authorization requests, claims records, and the provision of case management services to identify recipients with special health care needs. In addition, DMAS provided the plans with a monthly transition report which identified potential special needs enrollees by the use of certain atypical medications, special procedure codes, prior authorization approvals, and pregnancy information. Another means by which the plans obtain information on potential special needs recipients is through the Health Status Assessment form which is completed by the enrollment broker at the time of MCO enrollment.

Upcoming Waiver Period For items a. through h. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Please check all the items which apply to the State or MCO/PHP.

a. √ The State has required care coordination/case management services the MCO/PHP shall provide for individuals with special health care needs. Please describe by population.

The State Plan requires case management services to be provided for high risk pregnant women and children under two years of age. In addition to these services, the MCOs also provide coordination of services for other special needs populations to minimize fragmentation of care, reduce barriers, and link enrollees with appropriate services to ensure comprehensive, continuous health care. The MCOs must also provide case management services for infants in neonatal intensive care.

The Medallion II contract stipulates that each participating MCO have in place a primary care system of care delivery that includes a comprehensive plan of care for an enrollee with

special needs and that uses a coordinated and continuous case management approach involving the enrollee and, as appropriate, the enrollee's family or caregiver in all aspects of care including primary, acute, tertiary, and home care.

In order to comply with the current BBA regulations, the Medallion II contract will be amended to address the requirement of individual assessments for each new managed care recipient, *to the extent possible*.

b. √ As part of its criteria for contracting with an MCO/PHP, the State assesses the MCO/PHP's skill and experience level in accommodating people with special needs. Please describe by population.

Under the terms of the Medallion II contract, each MCO must ensure that its delivery system has available, accessible, and adequate numbers of facilities, locations, and personnel for the provision of all covered services. The MCOs are encouraged to develop and maintain a list of referral sources which includes community agencies, State agencies, "safety net" providers, teaching institutions and facilities to ensure that enrollees have access to and receive the full continuum of treatment and rehabilitative medical and outpatient mental health services and support.

All of the participating health plans have contractual arrangements with all hospitals in the localities that they serve which includes specialty facilities that host numerous specialists, ancillary providers, and support systems. These types of arrangements with specialty hospitals as well as those with tertiary care/teaching hospitals facilitate access to the best and most experienced health care providers in the region. The MCOs must also have procedures in place for allowing enrollees with disabling conditions or chronic illnesses to request that their PCP be a specialist. When specialists act as PCPs, the services they provide must be within the scope of their specialist's license.

DMAS ensures that people with special health care needs have access to "experienced" providers by assisting MCOs in the development of their networks. DMAS gives the MCOs a listing of all providers who are currently enrolled with Medicaid.

Recruiting these existing Medicaid PCPs and specialty providers, who are familiar with the challenges of providing quality care to the Medicaid population and who already have these patients in their panels, helps to ensure continuity of care for the recipients.

Prior to signing a contract with an MCO, DMAS also conducts a county by county network analysis to ensure compliance with provider staffing ratios required by the Medallion II contract. DMAS will compare the location and number of providers and hospitals to the residential zip codes of recipients. Each MCO also submits a list of all of the "special needs" providers in their network. The State monitors this report to ensure there are adequate numbers of "special needs" providers and that they are accessible to recipients needing their services. MCOs submit monthly reports which identify provider network additions and deletions. If there is the potential for reduced access to providers, the MCO must then submit a corrective action plan to DMAS which outlines what steps will be taken and the timeframes for completion to bring the network "whole" again.

c.___ The State requires MCOs/PHPs to either contract or create arrangements with providers who have traditionally served people with special needs, for example, Ryan White providers and agencies which provide care to homeless individuals. If checked, please describe by population.

d. √ The State has provisions in contracts with MCOs/PHPs which allow beneficiaries who utilize specialists frequently for their health care to be allowed to maintain these types of specialists as PCPs. If **not** checked, please explain by population.

e. √ The State collects or requires MCOs/PHPs to collect population-specific data for special populations. Please describe by population.

f.___ The State requires MCOs/PHPs that enroll people with special health care needs to provide special services, have unique medical necessity definitions and/or have unique service authorization policies and procedures.

1. Please note any services marked in the table in Section A.III.d.1 that are for special needs populations only by population.

2. Please note for Section C.II.b any unique definitions of "medically necessary services" for special needs populations by population.

3. Please note for Section C.II.d any unique written policies and procedures for service authorizations for special needs populations by population. For example, are MCOs required to coordinate referrals and authorizations of services with the State's Title V agency for any special needs children who qualify for Title V assistance.

g. √ The State requires MCOs/PHPs to identify individuals with complex or serious medical conditions in the following ways:

1. √ An initial and/or ongoing assessment of those conditions
2. √ The identification of medical procedures to address and/or monitor the conditions.
3. ___ A treatment plan appropriate to those conditions that specifies an adequate number of direct access visits to specialists to accommodate implementation of the treatment plan.
4. ___ Other (please describe):

h. ___ The State specifies requirements of the MCO/PHPs for the special populations in the waiver that differ from those requirements described in previous sections and earlier in this section of the application. Please describe by population.

Section G. Complaints, Grievances, and Fair Hearings

MCOs/PHPs are required to have an internal grievance procedure approved in writing by the State agency, providing for prompt resolution of issues, and assuring participation of individuals with authority to order corrective action. The procedure allows an enrollee or a provider on behalf of an enrollee to challenge the denial of coverage of, or payment for services as required by 1932(b)(4) of the Act.

States are required to provide Medicaid enrollees with access to the State fair hearing process as required under 42 CFR 431 Subpart E, including:

- informing Medicaid enrollees about their fair hearing rights in a manner that assures notice at the time of an action,
- ensuring that enrollees may request continuation of benefits during a course of treatment during an appeal or reinstatement of services if State takes action without the advance notice and as required in accordance with State Policy consistent with fair hearings. The State must also inform enrollees of the procedures by which benefits can be continued for reinstated, and
- other requirements for fair hearings found in Subpart E.

I. Definitions:

Previous Waiver Period

a.___ During the last waiver period, complaints and grievances were defined differently than described in the waiver governing that period. The differences were:

Upcoming Waiver Period -- Please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response.

a. Please provide definitions used by the State for complaint, grievance, or appeal.

<u>Grievance</u>: An expression of dissatisfaction about any matter other than an "action" as defined under "appeal". Grievance also refers to the overall system that includes grievances and appeals handled at the MCO level and access to the State fair hearing process. Grievances include, but are not limited to, the quality of care or services provided and aspects of interpersonal relationships such as rudeness of a provider or employee or failure to respect the enrollee's rights.

<u>Appeal</u>: A request for review of an action which is defined as:

1) the denial or limited authorization of a requested service, including the type or level of service; 2) the reduction, suspension, or termination of a previously authorized service; 3) the denial, in whole or in part, of payment for a service; 4) the failure to provide services in a timely manner; 5) the failure of an MCO to act within the timeframes established for grievances and appeals resolution and notification; or 6) for a resident of a rural area with only one MCO, the denial of a Medicaid enrollee's request to exercise his or her right to obtain services outside the network.

In areas where one MCO and MEDALLION operate concurrently, appeals and grievances related to the MEDALLION PCCM program are handled within DMAS.

b. Please describe any special processes that the State has for persons with special needs.

II. State Requirements and State Monitoring Activities:

Previous Waiver Period

a.___ During the last waiver period, the grievance standards or State monitoring were different than described in the waiver governing that period. The differences were:

b. [Required for all elements checked in the previous waiver submittal] Please provide results from the State's monitoring efforts, including a summary of any analysis and corrective action taken with respect to complaints, grievances and fair hearings for the previous waiver period [items G.II.a and G.II.b of the 1999 initial preprint; as applicable in 1995 preprint]. Also, please provide summary information on the types of complaints, grievances or fair hearings during the previous two-year period following this addendum. Please note how access and quality of care concerns were addressed in the State's Quality Improvement Strategy.

The top two complaint categories for the Medallion II program in calendar years 2001 and 2002 were administrative and access. Recipients not receiving their ID cards on time was the main administrative issue with 41.7% and 59.4%, respectively, of total complaints. Transportation was the main access issue with 34.2% and 25.4%, respectively, of total complaints. Transportation issues were compounded due to the implementation of DMAS contracting with transportation

vendors effective July 1, 2001 for all fee-for-service and MEDALLION recipients. Contract modifications were made in the fiscal year beginning July 2002 that requires all MCOs to mail ID cards by first class mail. Additionally, new reports have been identified that will enable DMAS to track and trend possible problems and recommend solutions.

Please see Attachment G.II.b. at the end of this section for a summary chart of complaints and grievances for calendar years 2001 and 2002.

As part of the State's Quality Improvement Strategy, DMAS required the MCOs to have in place a mechanism to link its enrollee complaints, grievances, and appeals system to the QIP. The MCOs were required to track trends in complaints and grievances and incorporate this information into the QI process. DMAS required that the MCOs' complaints and grievances system be consistent with the most current NCQA standards and DMAS guidelines.

c. Please mark any of the following that apply:

1. √ A hotline was maintained which handles any type of inquiry, complaint, or problem.

2. √ Following this section is a list or chart of the number and types of complaints and/or grievances handled during the waiver period.

   See Attachment B.I.b.10. - Managed Care Complaint Reports – Calendar Year 2002 and Managed Care Complaint Reports – Calendar Year 2001

3. ___ There is consumer involvement in the grievance process. Please describe.

Upcoming Waiver Period -- For items a. and b. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Please check any State requirements and State monitoring activities in effect for MCO/PHP grievance processes.

a. Required Complaints, Grievances, and Fair Hearings Elements:

1. √ The State requires MCO/PHPs to have a written internal grievance procedure, providing for prompt resolution of issues and assuring participation of individuals in authority.

2. √ The MCO/PHP grievance process is approved by the State prior to its implementation.

3. √ An MCO/PHP enrollee can request a State fair hearing under the State's Fair Hearing process. Please explain how, under what circumstances (i.e., direct access or exhaustion), and when an enrollee can access the State Fair Hearing process.

An enrollee can bypass the MCO process and can appeal directly to DMAS for a fair hearing. If an enrollee wishes to file an appeal with DMAS, the appeal must be filed within thirty (30) days of the enrollee's receipt of notice of any action to deny, delay, terminate, reduce, or deny payment for Medicaid covered services unless good cause exists.

Good cause includes, but is not limited to, situations or events where:

a) **Appellant was seriously ill and was prevented from contacting the MCO;**
b) **Appellant did not receive notice of the MCO's decision;**
c) **Appellant sent the request for appeal to another government agency in good faith within the time limit; or**
d) **Unusual or unavoidable circumstances prevented timely filing.**

If the MCO's notice is "defective" i.e., does not contain the required elements, good cause may exist.

If the enrollee files an appeal or grievance directly with the MCO, any formal grievance decision by the MCO may be appealed by the enrollee to DMAS for a fair hearing in accordance with the State's Client Appeals regulations at 12 VAC 30-110-10 *et seq*. DMAS will conduct an evidentiary hearing where a hearing officer will review all agency determinations which are properly

appealed; conduct informal, fact-gathering hearings; evaluate evidence presented; and issue a written final decision. The MCO must comply with DMAS' fair hearing decisions which are final and are not be subject to appeal by the MCO. The MCO must provide to DMAS all information necessary for any enrollee appeal at least ten days prior to the date of the hearing.

The MCO must educate its enrollees of their right to appeal directly to DMAS instead of or in addition to filing a grievance and appeal with the MCO.

4. √ Enrollees are informed about their fair hearing rights at the time of Medicaid eligibility determination and at the time of any action as defined in 42 C.F.R. 431 Subpart E.

5. √** The State ensures that enrollees may request continuation of benefits or reinstatement of services during a course of treatment during a fair hearing appeal. The State informs enrollees of the procedures by which benefits can be continued or reinstated.

6. √** Enrollees are informed about their complaint, grievance, and fair hearing rights at the time of MCO/PHP enrollment and/or on a periodic basis thereafter. Please specify how and through what means enrollees are informed.

The MCOs are required to provide each enrollee a handbook prior to the first day of the month in which enrollment starts. Once a year, DMAS notifies managed care enrollees of their right to request and obtain this information from the MCOs.

The handbook must include a description of the informal and formal grievance procedures including, but not limited to, the issues that may be resolved through the informal or formal grievance or appeals processes and the fact that enrollees have the right to appeal directly to DMAS. The handbook provides DMAS' address for appeals, the process for obtaining necessary forms, and procedures to register a grievance or appeal with the MCO.

b. Optional Complaints, Grievances, and Fair Hearings Elements:

1. _√_ The internal grievance procedure required by the State is characterized by the following (please check any of the following optional procedures that apply to the State's required grievance procedure):

   (a)_√_ The MCO/PHP governing body approves the grievance procedure and is responsible for the effective operation of the grievance process.

   (b)__ The governing body or its delegated grievance committee reviews and resolves complaints and grievances. If the State has any committee composition requirements please list_____

   (c)_√_ Reviews requests for reconsideration of initial decisions not to provide or pay for a service.

   (d)_√_ Specifies a time frame from the date of action for the enrollee to request a grievance resolution or fair hearing. Specify the time frame **_30 days_**

   (e)_√_ Includes time frames for resolution of grievances for MCO/PHP grievances. Specify the time frame set by the State

   MCOs must issue informal grievance decisions within seven days from the date of initial receipt of the grievance. The informal decision is not required to be in writing. MCOs must issue formal grievance decisions in writing within 14 days from the date of initial receipt of the formal grievance.

   (f)_√_ Establishes and maintains an expedited grievance review process for the following reasons: **emergency medical necessity**. Specify the time frame set by the State for this process **within 48 hours**.

   (g)_√_ Permits enrollees to appear before MCO/PHP personnel responsible for resolving the grievance.

   (h)_√_ Provides that, if the grievance decision is adverse to the enrollee, the grievance decision and any supporting documentation is forwarded to the State

within a time frame specified by the State. Specify the time frame.

MCOs must provide DMAS with a copy of the formal grievance decision concurrently with the provision of the decision to the client.

(i) _√_ The MCO/PHP acknowledges receipt of each complaint and grievance when received and explains to the enrollee the process to be followed in resolving his or her issue. If the State has a time frame for MCOs/PHPs to acknowledge complaints and grievances, please specify:

The MCOs must promptly provide grievance forms and written procedures to clients who wish to register written grievances.

(j) _√_ Gives enrollees assistance completing forms or other assistance necessary in filing complaints or grievances (or as complaints and grievances are being resolved).

(k) _√_ Conducts grievance resolution/hearings using impartial individuals not involved in previous levels of decision making.

(l) _√**_ If the focus of the grievance is a denial based on lack of medical necessity, one of the reviewers is a ~~physician with appropriate expertise~~ **health care professional who has the appropriate clinical expertise, as determined by the State**, in the field of medicine that encompasses the enrollee's condition or disease.

(m) _√_ Bases the MCO/PHP's decision on the record of the case.

(n) _√_ Notifies the enrollee in writing of the grievance decision and further opportunities for appeal, as well as the procedures available to challenge or appeal the decision.

(o) _√_ Upon request, provides enrollees and potential

enrollees with aggregate information regarding the nature of enrollee complaints and grievances and their resolution.

(p)__ Sets time frames for the MCO/PHP to authorize or provide a service if decision is overturned or reversed through the grievance or fair hearing process. Specify the time frame____

(q)_√_ Informs the enrollee of any applicable mechanism for resolving the issue external to the MCOs/PHPs own processes.

(r)__ Determines whether the issue is to be resolved through the grievance process, the process for making initial determinations on coverage and payment, or the process for resolution of disputed initial determinations.

(s)__ Other (please explain):

2._√_ MCOs/PHPs maintain a log of all complaints and grievances and their resolution.

3._√_ MCOs/PHPs send the State a summary of complaints and grievances on at least an annual basis.

4._√_ The State requires MCOs/PHPs to maintain, aggregate, and analyze information on the nature of issues raised by enrollees and on their resolution.

5.___ The State requires MCOs/PHPs to conduct in-depth reviews of providers or services identified through summary reports as having undesirable trends in complaints and grievances.

6._**_ The State and/or MCO/PHP have ombudprograms to assist enrollees in the complaint, grievance, and fair hearing process.

Even though this was checked in the prior waiver, Medicaid is exempt from the State's Ombudsman program effective July 1, 2000.

7.___ Other (please specify):

Attachment G.II.b

MEDALLION II - COMPLAINTS	Jan. 2001 - Dec. 2001		Jan. 2002 – Jun. 2002	
	Number	Percentage	Number	Percentage
Access to Health Services	170	2.3%	142	2.4%
Access to Transportation Services	2,483	34.2%	1,531	25.4%
Utilization & Medical Management	82	1.1%	22	0.4%
Provider Care & Treatment	261	3.6%	119	2.0%
Services Related to Quality	161	2.2%	101	1.7%
Admin. Serv. Related to ID Cards	3,027	41.7%	3,580	59.4%
Admin Serv. Not Related to ID Cards	259	3.6%	49	0.8%
Payment and Reimbursement	812	11.2%	478	7.9%
Total Complaints	7,255	100.0%	6,022	100.0%

Section H. Enrollee Information and Rights

This section describes the process for informing enrollees and potential enrollees receive about the waiver program, and protecting their rights once enrolled. The information in this section (e.g., enrollee handbooks, enrollment information, PCP choice materials) is considered to be marketing material because it is sent directly to enrollees. However, the traditional marketing materials (e.g., billboards, direct mail, television and radio advertising) are addressed above in Section A (see A.III.a).

I. Enrollee Information - Understandable to Enrollees:

Previous Waiver Period

a.____ During the last waiver period, the requirements for understandable enrollee information operated differently than described in the waiver governing that period. The differences were:

b. [Required] Please provide copies of the brochure and informational materials explaining the program and how to enroll.

Copies of the brochures and informational materials, including provider directories, explaining the Medallion II program are included as Attachment H.I.b.

Upcoming Waiver Period -- This section describes how the State ensures information about the waiver program is understandable to enrollees and potential enrollees. Please check all the items which apply to the State or MCO/PHP. For all items in this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Items which are required have "[Required]" in front of them. Checking a required item affirms the State's intent to comply. If the State does not check a required item, please explain why.

a. √ [Required] The State will ensure that enrollee materials provided to enrollees by the State, the enrollment broker, and the MCO/PHP are clear and easily understandable.

b. √ Enrollee materials will be translated into the languages listed below (If the State does not translate enrollee materials, please explain):

Spanish

The State has chosen these languages because (check any that

apply):

1.__ The languages comprise all prevalent languages in the MCO/PHP service area.

2._√_ The languages comprise all languages in the MCO/PHP service area spoken by approximately __**5**__ percent or more of the population **(by Medallion II region)**.

According to published census information, the only area that is close to the 5% threshold is Northern Virginia.

DMAS has identified the need for materials to be translated into Spanish even though the 5% threshold for a region has not yet been met. Therefore, recipients receive from DMAS pre-assignment, confirmation, open enrollment, and recipient rights letters in both English and Spanish. In addition, all comparison charts are distributed in both English and Spanish.

3.__ Other (please explain):

c._√_ Program information is available and understandable to non-English speaking enrollees whose language needs are not met through the provision of translated material described above. Please describe.

Translator services are available through all MCOs and the Managed Care Helpline. Some MCOs also have staff within their organizations who are bi- or multi-lingual. DMAS has a language symbol on all printed materials instructing readers to call the toll-free Managed Care Helpline for translator services. The languages represented on the symbol are Spanish, Vietnamese, Farsi, Hindi, Arabic, and Korean. These include the top five language requests received by the Managed Care Helpline over the past six years.

d._√_ [Required] Translation services are available to all enrollees, regardless of languages.

e._√_ Every new enrollee will have access to a toll-free number to call for questions. Please note if the State requires TTY/TDD for those with hearing/speech impairments:

The MCOs and the enrollment broker are required to provide TTY/TDD services for those with hearing impairments.

f. √** The State requires MCO/PHP enrollee information materials to be translated into alternative formats for those with visual impairments.

II. Enrollee Information - Content:

Previous Waiver Period

a.___ During the last waiver period, the enrollee information requirements operated differently than described in the waiver governing that period. The differences were:

Upcoming Waiver Period -- This section describes the types of information given to enrollees and potential enrollees. Please check all that apply. For all items in this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Items which are required have "[Required]" in front of them. Checking a required item affirms the State's intent to comply. If a required item is not check, please explain why.

a. Information provided by the State and/or its Enrollment Broker. The State and/or its enrollment broker provides the following information to enrollees and potential enrollees.

1.___ Every new enrollee will be given a brief in-person presentation describing how to appropriately access services under the managed care system and advising them of enrollees' rights and responsibilities

2.__√__ An initial notification letter

3.__√__ Informational materials describing how to appropriately access services under the managed care system and advising them of enrollees' rights and responsibilities.

Potential MCO enrollees receive a pre-assignment packet that includes a letter advising them of their choices and instructing them to make a choice. They also receive an MCO brochure and comparison chart that contains information on how to access services, enrollee rights, benefits available, MCOs available in their area, and time frames for selection. All documents are translated into Spanish.

4.___ A form for enrollment in the waiver program and selection of a plan

5._√_ A list of plans serving the enrollee's geographical area

6._√_ Comparative information about plans

7._√_ Information on how to obtain counseling on choice of MCOs/PHPs

8.___ Detailed provider network listings

9._√_ A new Medicaid card which includes the plan's name and telephone number or a sticker noting the plan and/or PCP's name and telephone number to be attached to the original Medicaid card (please specify which method);

Enrollees receive an ID card from their MCO which contains the MCO's name and telephone number, PCP's name and telephone number, as well as other pertinent information from their MCO. These cards are issued upon initial enrollment into Medallion II. For those enrolled in MEDALLION, DMAS issues an ID card which contains the contact phone number for the MEDALLION PCCM program, the PCP's name, address, and telephone number, as well as other pertinent information. ID cards may be reissued upon enrollee's request or when triggered by changes to the recipient's PCP selection or address.

10.___A health risk assessment form to identify conditions requiring immediate attention.

Health risk assessment forms are completed on enrollees who call the enrollment broker to enroll into or change their MCO. The forms are forwarded to the MCOs to aid in the transition of services from fee-for-service to managed care and to facilitate appropriate health care and case management services. These health risk assessment forms help the MCOs to identify children with special health care needs and other populations with special needs.

11._√_Information concerning the availability of special services,

expertise, and experience offered by MCO/PHPs and providers

Members receive a comparison chart of all MCOs in their service area. These charts include information about the additional benefits and special services offered by the MCO or PCCM program.

12. √ [Required] Information explaining the grievance procedures and how to exercise due process rights and their fair hearing rights.

13. √ [Required for MCOs with lock-in periods] Information about their right to disenroll without cause the first 90 days of each enrollment period. (See A.III.b.5)

14. √ [Required for MCOs] Information on how to obtain services not covered by the MCO/PHP but covered under the State plan.

15. √ [Required for MCOs] For enrollees in lock-in period, notification 60 days prior to end of enrollment period of right to change MCOs/PHPs (See A.III.b.5)

DMAS notifies enrollees of their right to change MCOs 60 days prior to the end of their enrollment period. This notification includes the "Annual Notice of Health Care Rights". Please see Attachment A.III.b.4.d.

Open enrollment periods vary by Medallion II region. Attached is a map and chart showing the open enrollment regions and periods for each region (locality). See Attachment H.II.a.15. for the chart and Attachment B.III.a.4. for the map.

16. __ Other items (please explain):

b. Information provided by the MCO/PHP The State requires the MCO/PHP to provide, written information on the following items to enrollees and potential enrolles. Unless otherwise noted, required items must be provided upon actual enrollment into the MCO/PHP (the BBA requires some information be provided only upon request). Please check all that apply.

1. √ [MCOs required to provide upon request] Enrollee rights.

2. √ [MCOs required to provide upon request] Enrollee responsibilities.

3. √ [MCOs required to provide upon request] Names, locations, qualifications and availability of network providers, including information about which providers are accepting new Medicaid enrollees and any restrictions on enrollees' ability to select from among network providers.

   This information is provided to recipients by the MCOs in their provider directories. A directory is furnished at the time of initial enrollment and upon request. In addition, recipients may call the MCOs' toll-free numbers to ask questions about network providers. A copy of a network provider directory from each MCO is included in Attachment H.I.b.

4. √ [MCOs required to provide upon request] Amount, duration and scope of all benefits (included and excluded).

5. √ [MCOs required to provide upon request] Physician incentive program, including (1) if the MCO has a PIP that covers referral services; (2) the type of incentive arrangement; (3) whether stop-loss protection is provided; and (4) a summary of survey results, if a survey is required.

6. √ [Required for MCOs] The MCO enrollee materials (either through the enrollee handbook, semi-annual or annual open enrollment materials, or by some other means) annually disclose to enrollees their right to adequate and timely information related to physician incentives.

7. √ [MCOs and PHPs required to provide upon request *and* upon enrollment] Information explaining the complaints and grievance procedures for resolving enrollee issues, including issues relating to authorization of, coverage of, or payment for services.

8. √ [Required for MCOs] Procedures for obtaining services, including authorization requirements.

9. √ [Required for MCOs] After-hours and emergency coverage.

The State ensures enrollee access to emergency services by requiring the MCO to provide the following information to all enrollees [note: these items are required of MCOs only; however, please fill in if applicable for PHPs]:

i. __√__ the right to use participating and non-participating providers

ii. __√__ definition of emergency services

iii. __√__ the prudent layperson definition of emergency medical condition

iv. __√__ the prohibition on retrospective denials for services that meet the prudent layperson definitions (e.g., to treat what appeared to the enrollee to be an emergency medical condition at the time the enrollee presents at an emergency room)

v. __√__ the right to access emergency services without prior authorization

10. __√__ [Required for MCOs] Procedures for obtaining non-covered or out-of-area services.

11. __√__ [Required for MCOs] Any special conditions or charges that may apply to obtaining services.

12. __√__ [Required for MCOs and PHPs] The right to obtain family planning services from any Medicaid-participating provider

13. __√__ [Required for MCOs] Policies on referrals for specialty care and other services not furnished by the enrollee's primary care provider.

14. __√__ [Required for MCOs] Charges to enrollees, if applicable.

15. __√__ [Required for MCOs] Procedures for changing primary care providers.

16. __√__ Procedures for obtaining mental health, substance abuse, and developmental disability services.

17. __ Procedures for recommending changes in policies or

services.

18._√_ The covered service area.

19._√ Notification of termination or changes in benefits, services, service sites, or affiliated providers (if the enrollee is affected). Notices are provided in a timely manner.

20.__ A description of new technology or new technology acceptance policies which are included as covered benefits.

21._√_ Enrollees' right to obtain information about the MCO/PHP, including information standards, utilization control procedures and the financial condition of the organization.

22.__ Other (please describe):

III. Enrollee Rights:

Previous Waiver Period

a.___ During the last waiver period, the requirements for enrollee rights operated differently than described in the waiver governing that period. The differences were:

Upcoming Waiver Period -- For items a. through n. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Please check any of the processes and procedures in the following list the State requires to ensure that contracting MCOs/PHPs protect enrollee rights. The State requires MCOs/PHPs to:

a._√_ Have written policies with respect to enrollee rights.

b._√_ Communicate policies to enrollees, staff and providers.

c._√_ Monitor and promote compliance with their policies by staff and providers.

d._√_ Ensure compliance with Federal and State laws affecting the rights of enrollees such as all Civil rights and anti-discrimination laws **and other laws regarding privacy and confidentiality.**

e._√_ Implement procedures to ensure the confidentiality of health and medical records and of other information about enrollees.

f. √ Implement procedures to ensure that enrollees are not discriminated against in the delivery of medically necessary services.

g. √ Ensure that all services, both clinical and non-clinical, are accessible to all enrollees, including special populations.

h. √ Ensure that each enrollee may select his or her primary care provider from among those accepting new Medicaid enrollees.

i. √ Ensure that each enrollee has the right to refuse care from specific providers.

j. √ Have specific written policies and procedures that allow enrollees to have access to his or her medical records in accordance with applicable Federal and State laws **and that allows enrollees to request that they be amended or corrected, as specified in 45 CFR ξ164.524 and 164.526.**

k. √ Comply with requirements of Federal and State law with respect to advance directives.

l. √ Have specific written policies that allow enrollees to receive information on available treatment options or alternative courses of care, ~~regardless of whether or not they are a covered benefit,~~ **which is presented in a manner appropriate to the enrollee's condition and ability to understand.**

m. Allow direct access to specialists for beneficiaries with long-term or chronic care needs (e.g., severely and persistently mentally ill adults or severely emotionally disturbed children)

n. √** Other (please describe):

The enrollee has the right to:

1. **Be treated with respect and with due consideration for his or her dignity and privacy.**
2. **Participate in decisions regarding his or her health care, including the right to refuse treatment.**
3. **Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other federal regulations on the use of restraints and seclusion.**

The State must ensure that each enrollee is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCOs and their providers or the State agency treats the enrollee.

IV. Monitoring Compliance with Enrollee Information and Enrollee Rights

Previous Waiver Period

a.___ During the last waiver period, the State monitored compliance with enrollee information and rights differently than described in the waiver governing that period. The differences were:

d. [Required for all elements checked in the previous waiver submittal] Please include- the results from monitoring MCO/PHP enrollee information and rights in the previous two year period, including a summary of any analysis and corrective action taken [items H.IV.a-d of 1999 initial preprint; item A.22 of 1995 preprint].

DMAS routinely monitors MCO enrollee information and rights. Complaint tracking and analysis is one primary method. Enrollee rights and the grievance process were items evaluated in the June 2002 MCO site visits. Enrollee rights are evaluated through complaint reports (Attachment B.I.B.10.) and through DMAS' evaluation of MCO recipient materials.

MCOs are required to include information on enrollee rights in their handbooks and brochures. DMAS notifies MCO enrollees of their rights in the annual re-enrollment package. Surveys conducted by independent contractors also question recipients about their understanding of their health plan provisions including their rights under the plan.

Upcoming Waiver Period -- For items a. through d. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Please check any of the processes and procedures the State uses to monitor compliance with its requirements for enrollee information and rights.

a._√_ The State tracks disenrollments and reasons for disenrollments or requires MCOs/PHPs to track disenrollments and reasons for disenrollments and to submit a summary to the State on at least an

annual basis.

b. _√_ The State will approve enrollee information prior to its release by the MCO/PHP.

c. _√_ The State will monitor MCO/PHP enrollee materials for compliance in the following manner (please describe):

DMAS must approve all MCO enrollee enrollment and marketing materials for compliance and content before these materials can be distributed to enrollees.

d. _√_ The State will monitor the MCO/PHPs compliance with the enrollee rights provisions in the following manner (please describe):

The Managed Care and DMAS Helplines, the Managed Care Division of DMAS, and the MCOs receive complaints from recipients on managed care issues including reported violations of enrollee rights. All documented complaints are investigated and resolved. DMAS tracks complaints and reviews them to identify any trends that should be addressed by the MCOs.

DMAS conducts MCO contract compliance monitoring on an ongoing basis. Some of the areas monitored relate to enrollee rights and include: written information on enrollee rights provided by the MCOs; information on treatment options; participation in health care decisions; access to medical records; confidentiality; enrollee-provider communications; marketing activities; and the MCO's grievance and appeals processes. DMAS sends an annual written report to each MCO monitored. The MCOs are required to address any problem areas identified within specified time frames.

In addition, DMAS and the MCOs conduct recipient CAHPS satisfaction surveys of managed care enrollees. The survey includes questions related to recipient rights, courteous treatment, access to emergency and family planning services, and receipt and understanding of benefit information. DMAS reviews the results to determine areas that may need improvement.

Section I. Resource Guide

Below are references which provide information related to Medicaid managed care quality assessment and improvement efforts, and rate setting and risk adjustment methodologies:

Actuarial Research Corporation, Report prepared for the Department of Health and Human Services (DHHS)/the Health Care Financing Administration (HCFA), Capitation Rate Setting in Areas with Eroded Fee-For-Service Base Final Report, 1992.

Actuarial Research Corporation, Setting an Upper Payment Limit Where the Fee for Services Base is Inadequate: Final Report, 1992.

Alpha Center, Report produced for the Robert Wood Johnson Foundation, Risk Adjustment: A Special Report, 1997.

Ann Arbor Actuaries, Inc., Report prepared for DHSS/HCFA, A Review of Rate Setting Methods of Selected State Medicaid Agencies for Prepaid Health Plans, 1991.

Ann Arbor Actuaries, Inc., Report prepared for DHSS/HCFA, Actuarially Sound Rate Setting Methodologies, 1991.

Conference Report 105-217 to accompany H.R. 2015, the Balanced Budget Act of 1997, (Section 4705 and the regulations being developed to implement these requirements).

Foundation for Accountability (FACCT), Foundation for Accountability (FACCT) Guidebook for Performance Measurement Prototype Summary, 1995.

Independent Assessment Guide Document, Health Care Financing Administration, December, 1998.

Joint Commission for Accreditation of Healthcare Organizations, National Library of Health Care Indicators, 1997.

Massachusetts Medical Society, Quality of Care: Selections from The New England Journal of Medicine, 1997.

Mathematica Policy Research, Inc, The Quality Assurance Reform Initiative (QARI) Demonstration For Medicaid Managed Care: Final Evaluation Report, 1996.

MEDSTAT Group, Report prepared for U.S. DHHS/HCFA, A Guide for States: Collecting and Analyzing Medicaid Managed Care Data, 1997.

MEDSTAT Group, Report prepared for U.S. DHHS/HCFA, Survey of Key Performance Indicators, 1997.

Medicaid Management Institute of the American Public Welfare Associations, report prepared for DHHS/HCFA, Medicaid Primary Care Case Management Programs: Guide for Implementation and Quality Improvement, 1993.

Merlis, Mark for National Governor's Association (NGA), Medicaid Contracts with HMOs and Pre Paid Health Plans: A Handbook for State Managers, 1987. (**Rate Setting Description still applicable)

National Academy for State Health Policy, Quality Improvement Primer For Medicaid Managed Care, 1995.

National Academy for State Health Policy, Quality Improvement Standards and Processes Used by Select Public and Private Entities to Monitor Performance of Managed Care: A Summary, 1995.

National Academy for State Health Policy, Report prepared for HCFA, Quality Improvement System for Managed Care, 1997.

National Committee for Quality Assurance (NCQA), Health Plan Employer Data and Information Set (HEDIS © Current Version).

President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry, Final report to the President of the United States, Quality First: Better Health Care for All Americans, 1998.

U.S. DHHS/HCFA, A Health Care Quality Improvement System for Medicaid Managed Care: A Guide for States, 1993.

U.S. DHHS/PHS/AHCPR, Conquest 1.1: A Computerized Needs-Oriented Quality Measurement Evaluation System, 1996.

U.S. DHHS/PHS/AHCPR, Consumer Assessment of Health Plans (CAHPS) Satisfaction Survey, 1997.

U.S. DHHS/PHS/AHCPR, Putting Research to Work in Quality Improvement and Quality Assurance: Summary Report, 1993, Publication No. 93-0034.

U.S. DHHS/PHS/AHCPR Research Activities Newsletter, Monthly publication.

U.S. DHHS/HCFA and National Committee on Quality Assurance (NCQA), Health Care Quality Improvement Studies in Managed Care Settings: Design and Assessment: A Guide for State Medicaid Agencies, 1994, Purchase Order #HCFA-92-1279.

U.S. DHHS/HCFA/American Public Welfare Association (APWA), Monitoring Risk-Based Managed Care Plans: A Guide for State Medicaid Agencies.

U.S. DHHS/PHS/SAMHSA, Managed Care Initiative Quality Improvement Publications: "Managing Managed Care: Quality Improvement in Behavioral Health."*

U.S. DHHS/PHS/SAMHSA, Managed Care Initiative Technical Assistance Publications: Volume One, "An Evaluation of Contracts Between Managed Care Organizations and Community Mental Health and Substance Abuse Treatment and Prevention Agencies."*

U.S. DHHS/PHS/SAMHSA, Managed Care Initiative Technical Assistance Publications: Volume Two, "An Evaluation of Contracts Between State Medicaid Agencies and Managed Care Organizations for the Prevention and Treatment of Mental Illness and Substance Abuse Disorders."*

U.S. DHHS/PHS/SAMHSA, Managed Care Initiative Technical Assistance Publications: Volume Seven, "Technical Assistance Publication Series (TAP) 22: Contracting for Managed Substance Abuse and Mental Health Services: A Guide for Public Purchasers."*

Websites: www.hcfa.gov, www.ahcpr.gov or outside organizations such as www.ncqa.org, www.nashp.org, www.samhsa.gov, www.apwa.org.

*document can be ordered through the National Clearinghouse on Alcohol and Drug Information (NCADI) 800/729-6686 or found on the SAMHSA Web Site at www.samhsa.gov/mc/TAS.htm.